PARENT MANAGEMENT SELF-EFFICACY : AN INVESTIGATION.

A thesis

submitted in partial fulfilment

of the requirements for the Degree

of

Master of Arts in Psychology

in the

University of Canterbury

by

Michael Robert Prouting

University of Canterbury

1988

ACKNOWLEDGEMENTS

At this point in time it would be appropriate to thank a number of people and things for their assistance in the completion of this research thesis. I know more about my subject material and of myself than when I started, so I am grateful to the intrinsic process of writing such a project.

Dr.Bill Watkins and Karyn France for their support in the initial stages of setting up this project.

A grateful thanks to my family who have accepted my poverty of finance and conversation over this time. Especially my father, Bob, who gave me subtle encouragement to complete this work.

Thank you Steve Hudson for labouring with me and helping me 'squeeze' when I would rather have 'kicked'. Controlling and directing my energies when they started to dissipate.

To all my current friends and those who are further from me at this time, thank you from the depths of my heart for accepting me even through the misunderstandings and confusion. This has been a memorable journey.

I am very grateful to the families who participated in this research. I am the richer for knowing them.

Thank you Kay Faulls for supporting me in my final hours.

I am especially grateful to the late Lorna Prouting, who continues to inspire me and gave me the gift of laughter and fun.

SHALOM TO ALL.

ABSTRACT

This study was attempted to investigate parent management self-efficacy of children. The social-learning theory and the self-efficacy construct were heuristic in explaining the role of management changes experienced while the families were involved in a child and family psychiatric unit.

A parent management self-efficacy questionnaire was designed to measure parents changing confidence during the inpatient/outpatient short-term intervention program. Specific questions were asked about management situations. It was administered twice weekly to both parents, of an admitted child. Behavioural measures were also completed by parents and staff, evaluating the child's progress.

The program lasts for 10 weeks, the first five being inpatient treatment and the outpatient follow-up completing the short-term therapeutic program. A 6 month follow-up was attempted for all families satisfactorily completing the research requirements.

Results from this study are tentative. They suggest that self-efficacy in child management is an important variable in the maintenance of healthy psychological change. Further refinement is necessary to establish the relationship between child behavioural performance, self-efficacy in management and therapeutic intervention provided by a child inpatient treatment. There is some indication that if management self-efficacy is not enhanced during the 10 week program, then long-term change is doubtful.

TABLE OF CONTENTS

TABLE OF TABLES

TABLE OF FIGURES

CHAPTER ONE - LITERATURE REVIEW

SECTION (A) - SELF-EFFICACY

1.1 INTRODUCTION AND SOCIAL LEARNING THEORY

Models of human functioning have no reality in themselves. They are attempts to explain or construe behaviour in terms that are more familiar. The 'as if' quality of theoretical metaphors can become 'reified' as immutable statements of reality. It is, therefore, important to recognise their purpose.

> "The primary function of models are to render a complex set of events manageable to provide templates to lay over selected aspects of reality in order to organise, explain and evaluate that chunk of reality " (Wine & Smye, 1981, p30).

Bandura (1986) claims that his explanation (or template) of human functioning is based on a model of triadic reciprocality. One of the fundamental principles of the social cognitive theory is this reciprocal deterministic mechanism that explains the interdependence between behaviour, mediational processes and the environment.

Social learning theory claims the existence of, and refers to the role of mediational cognitive activity for the individual. What the social learning theory has provided is a framework for describing the interdependence between cognitive and behavioural change. Cognitive changes are invariably hidden, though inferred, from the individual's performance, and are essential to the change

process. The techniques used in therapeutic interventions focus on producing behavioural change with inferred cognitive changes. Eastman and Marzillier (1984) have supported this re-direction of focus from non-cognitive, conditioning explanations to include cognitive determinants of change.

The essense of Bandura's proposal, and its greatest value, is that it accounts for some of the divergent trends in behaviour therapy (Bandura, 1977). The unifying quality of this theory brought two previously distinct trends together. Cognitive processes were increasingly being used to explain the acquisition and retention of behaviour, whereas, procedures, based on performance, were proving the most effective in bringing about change (Bandura, 1977). Poser (1978) agrees that self-efficacy has great heuristic value for the 'cognitization' of behaviour therapy.

Prior to the conception of the self-efficacy construct, behavioural analysis and social learning theory differed with respect to a number of criteria. For example, the difference in emphasis with respect to environmental events and inferred cognitive events, the descriptions of human functioning and the models they proposed. The explanations of causal processes involved in psychological functioning differed, and the implications for a technology of behaviour change derived from them were, and are, procedurally distinct. Behavioural analysis identifies causal and correlational relationships between environmental factors that impinge on the individual frum

the outside. There is no need to refer to internal mental events to explain human behaviour.

Psychological research and theory predominantly focuses on two aspects of human functioning. Firstly, the acquisition of knowledge and the process of learning, and secondly, the execution of response patterns of behaviour (Bandura, 1980). It is important, therefore, to consider the relationship between knowledge and action, cognitions and behaviour. Self-referent thought undoubtedly plays a crucial role in the relationship people experience between judgements of their capabilities and their actions. Cognitive processes are intrinsically involved in the developement of new behaviours and their retention over time. Actions, or a person's attempts at performing on a task are effected by their self-percepts of personal effectiveness (self-efficacy). For instance, in a vicarious learning situation , the experience of observation will facilitate the development of the subjects belief that they can emulate the model (Brody, 1980).

Undoubtedly, the social learning theory of behaviour has developed to address the gap between observed human behaviour and our explanations of what is experienced by the individual. Performance is important for the completion of a task. However, if the individual is going to maintain the behaviour and improve in performance , then it is also important to establish a theory and a construct to explain how a person feels and assesses their performance. A method to test this theory is then required.

1.2 COMPONENTS OF SELF-EFFICACY

Bandura (1977) defined efficacy expectations as 'the conviction' that one could successfully execute a behaviour. This requires a judgement of whether the individual is capable of accomplishing a certain level of performance. Outcome expectations are a person's 'estimate' that a given behaviour will lead to certain outcomes. This judgement assesses the likely consequence such a behaviour will produce. For example, the belief that one can jump six feet to clear a high-jump rod is an efficacy judgement; whereas, the anticipated social recognition and applause constitute the outcome expectations. An outcome is the consequence of the act, not the act itself (Bandura, 1986). Kazdin (1978) offered a similar explanation by defining self-efficacy expectations as an individual's appraisal of whether he/she can perform requisite behaviours, and outcome expectations as a person's beliefs about the results of certain behavioural performances.

Bandura (1978) suggests that self-efficacy expectations be based upon a subject's assessment of the degree to which they can or cannot cope with stressful events, that is, an individual's self-coping capabilities. One of the essential features of Bandura's definition of self-efficacy is a person's perceived ability to cope with a potentially aversive event (Eastman & Marzillier, 1984).

The analysis of an individual's personal effectiveness

attempts to clarify the mechanism through which expectations of self-efficacy are created and strengthened. Initiation and regulation of behaviour is partly governed by people's perceptions of their abilty to cope in certain situations. For example, Bandura and Adams (1977) discuss the function of perceived self-efficacy in the treatment of avoidant behaviours, and especially snake phobias. They recommended this type of subject because of four important criteria :

(1). a phobic dread of snakes has generalised debilitating effects on other activities and is very distressing;

(2). the phobic behaviour is relatively refractory to change;

(3). the level and generality of behavioural change can be assessed precisely;

(4). treatment effects are rarely confounded by extra-therapeitic encounters with the threats during the course of treatment.

Clarification of the causal contribution of self-efficacy to performance requires precise measurement of self-efficacy judgements and the gradations of behavioural change. An analysis of the mechanism of self-efficacy includes an investigation of the three components of the construct and their implications in future performance. The dimensions vary in :

a) the magnitude (or level) of self-efficacy, ranging from simpler to more difficult tasks. Some tasks are evaluated as being easier than others. Individuals assess and

establish their own limitations on their expectations of personal effectiveness.

b) generality of the self-efficacy belief, occuring beyond the specific treatment situation. Judgements of personal effectiveness can be in specific areas of behaviour, while others are across a wide range of activities and functions.

c) strength along a continuum from 'easily extinguishable' to 'persevering' behaviours, despite disconfirming experiences. The degree of correspondence between self-efficacy judgements and performance will vary depending on strength of the belief in one's capabilities.

The level, strength, and generality of an individual's self-efficacy will determine their choice of activities, how much effort they will expend and how long they will persist at a task. The stronger the perceived self-efficacy, the more active the individual is in coping efforts. An informative analysis of self-efficacy judgements requires the detailed assessment of magnitude, generality and strength (Bandura, 1986).

Particularised measures of self-efficacy must coinside with an adequate assessment of behaviour. Global measures of self-efficacy and performance, that are ill-defined, will undoubtedly yield discordances. Measurements taken in simulated situations will also provide disparities. Bandura (1977) has termed this close assessment between behaviour and perceptions of personal effectiveness as a

microanalytic methodology. Such methods permit an investigation of the degree of congruence between self-percepts of behaviour and action at the level of individual tasks. The dynamic interplay between self-referent thought, action and affect is of central interest to self-efficacy theory (Bandura, 1986).

1.3 THE CONTEXT OF SELF-EFFICACY THEORY

There have been numerous alternative attempts to explain and research human functioning requiring an analysis of environmental contingencies. For instance, there are examples in the Journal of Applied Behavioural Analysis using operant and classical conditioning theory to describe phenomena, the neo-behaviouristic model (Wolpe, 1976), cognitive behaviour modification (Beck, 1976; Meichenbaum, 1977), multi-modal behaviour therapy (Lazarus, 1976). Poser (1978) stresses that the self-efficacy theory should not be confused with other cognitive theories of human action such as effectance motive (White, 1959), self-esteem (Coopersmith, 1967), or locus of control (Rotter, 1966). Personal efficacy is not a motive disposition or personality trait.

The construct of self-efficacy, which is embedded in social learning theory (Bandura & Adams 1977; Kazdin, 1978) is considered closely related to other types of theoretical explanations. For instance, Maddux et al (1982) refer to self-efficacy theory as belonging to a larger family of theories commonly referred to as expectancy-value theories

(Bolles, 1972; Rogers & Newborn, 1976; Vroom, 1964). Goldfied and Robins (1982) focus on the notion of perceived mastery and social competence and draw some common characteristics with other personality theorists. For instance, a person's sense of competence, mastery or effectance is considered a central motivator of human behaviour (deCharms, 1968; Rotter, 1954; Seligman, 1975; White, 1959).

A central factor in these numerous explanations is their pro-phenomenological emphasis. Bandura, especially, has assigned central explanatory roles to phenomenal motive states (Brody, 1980). For example, Seligman's (1975) learned helplessness model focuses on uncontrollable aversive events, and especially the importance of outcome expectations. Outcome expectations play a crucial role in the development of learned helplessness and feelings of inadequacy. An individual believes they do not have any control over the consequences of their actions. Bandura focuses on purposive behaviour and its development. Believing in one's capabilities and acting confidently strengthens the likelihood of such behaviours being executed. Performances that leave one person happy can leave another person dissatisfied because their standards differ. Unreasonable standards can lead to very disheartening senses of failure. Both theorists posit expectancy mechanisms of action. Seligman focuses on uncontrollable aversive events as the major antecedent of helplessness, and Bandura sees mastery experiences as leading to self-efficacy (Poser, 1978). Poser even sggests

that Seligmann's term 'learned helplessness' comes close to being a negative version of personal efficacy.

The clarification of outcome and efficacy expectations has been addressed. It is important to the establishment of this theory that they are distinguished. Outcomes are certainly not separated from the acts performed. How one behaves largely determines the outcomes one experiences. Similarly, the types of outcomes anticipated depend largely on people's judgements of how well they will perform in given situations. It is because people see outcomes as contingent on the adequacy of their performances, and care about their outcomes, that they rely on self-judged efficacy in deciding which courses of action to pursue.

Compared to the broad trait conceptions such as locus of control (Rotter, 1954), self-efficacy is more detailed and does not postulate a static or global personality construct. Self-efficacy refers to an individual's specific interactions with their environment, thereby, specifying the nature of the situation, and the response. It also provides a broad applicability to other circumstances.

Self-efficacy theory has provided a means to further research related to cognitive mediating factors in the triadic causal chain. Bandura has regarded self-efficacy as an influential part of human psychological functioning, but acknowledges it as being one of a number of social determinants of behaviour. Due to the complex nature of human functioning, it is not surprising that Bandura's

theories have appeared somewhat over-simplified to critics or obtuse to others. Much has been made of self-efficacy research and theory in the last ten years and it has been of some concern, that as a theoretical construct, it might be elevated to the grandiose status in the explanation of human behaviour, in a way that other plausible constructs have been in the past, for example, learned helplessness and self-esteem (Eastman and Marzillier, 1984).

An evaluation of any theory is essential to its refinement and clarification. Wilson (1978) has suggested four important criteria for scientific theory.

1. Accomodate and integrate the currently known facts of behaviour change.
2. Be stated so it is testable in supporting or disconfirming by experiment.
3. Heuristic in stimulating novel research and prompting therapeutic innovations.
4. Compare favourably with theoretical alternatives.

He supports Bandura's theory as 'scientifically valuable' and suggests that it is extremely timely and useful for the development of present-day behaviour therapy.

The development of any theory is influenced by numerous factors. Predominantly, psychological theories have developed from a deterministic framework, and as Fritjof Capra (1982) would argue, a Western patriarchical culture. Descriptions of behaviour and human cognitions are limited to the amount of knowledge available to the researcher and their biases, both theoretical and personal. Cultures and world views influence our perception of the

world through formal and informal learning. They express our social values. Culture is a way of life, incorporating a method of transmission from one generation to another, and the development and maintenance of a belief system, including how to perceive and interpret the world (Lenz & Myerhoff, 1985). Wilson (1978) stresses this point in his discussion of the practices of therapists. A therapist's theoretical orientation is an important contributing factor in his/her discipline. The implicit philosophical and cultural milieu that we are exposed to in the Western world is less obvious, yet as influential in our thinking.

1.4 DEVELOPING PERCEPTIONS OF SELF-EFFICACY

Change involves new ways of thinking and new ways of acting. Self-efficacy theory has focused on this link between the cognitive and behavioural functioning of the individual. It addresses the complex and accessible process of human learning. This involves numerous judgements about personal abilities.

> " In contrast (to rats) humans engage in considerable self-reflective thought and boost or undermine their efforts by beliefs about their performance capabilities " (Bandura, 1978, p233).

The regulation of human behaviour involves a self-reflective component functioning during the acquisition of new observable behaviours. This involves both cognitive and behavioural competencies. This process is self-conscious. It enables individuals to analyse their experiences and develop this knowledge of the world around them. What is of interest to psychologists and other 'change' professionals, is how individuals can develop

their beliefs and how they can be modified.

Self-efficacy (a part of an individual's self-knowledge) is primarily based on four principal sources of information: performance attainments; vicarious experiences or observing the performances of others; verbal persuasion and other allied social influences relating to one's personal capabilities; and physiological states of arousal which people use to help judge their strength, vulnerability and capableness to function (dysfunction).

1.4.1 PERFORMANCE : Authentic mastery experiences (Bandura, Adams & Beyer, 1977; Biran & Wilson, 1981) provide the most influential sources of efficacy information. Successes raise efficacy appraisals, and repeated failures can lower them. Memories of how well one can execute courses of action enhance how one can deal with prospective situations. Self-percepts of efficacy are not inert estimates of future action, they continually influence choice of activities and environmental settings (Bandura, 1982). The generalisation of effects usually occur with behaviours that are most similar to the performance in which self-efficacy was enhanced. When individuals attribute poor performance to faulty strategies rather than inability to perform the task, failure can raise confidence that better strategies will bring future success (Bandura, 1986).

1.4.2 VICARIOUS INDUCTION : People develop general perceptions of how well they think they can cope under

specific situations. Watching others accomplish certain tasks can influence their feelings of self-efficacy. Social comparison is one of the pertinent ways of enhancing (or diminishing) our self-efficacy judgements. For example, observing someone else of similiar competence fail despite high effort would lower an observers judgement of their capabilities (Brown & Inouye, 1978). Models also teach observers methods of dealing with difficult situations, even when individuals have undergone many experiences confirming their inefficacy (Bandura, 1986). Certain situations such as uncertainty of one's capabilities or lacking direct knowledge of one's capablities can hinder the receptivity of the individual to developing new abilities and strengthening their self-efficacy (Takata & Takata, 1976).

1.4.3 PERSUASIVE INFORMATION : Often judgements of capability require influences from 'probabilistic indicants of talents' (Bandura, 1986). People have limited knowledge of what they can and cannot do especially in new situations. Self-appraisal is quite often based on the opinion of others. Persuasive efficacy influences have their greatest impact on people who have some reason to believe that they can produce effects through their actions (Chambliss & Murray, 1979a; 1979b). The more credible and expert the persuader, the more believable the source of information about one's performance capabilities, the more likely are judgements of personal efficacy to change.

Persuasion can often take the form of evaluative

feedback about ongoing performances. Schunk (1982a, 1983b) has demonstrated that feedback can affect judgements of one's capabilities and subsequent accomplishments. Positive appraisal of another's efficacy enhances their efforts when they are slightly beyond what individuals can do at the time. Achievement also builds trust between the persuader and the performer; failure may well undermine the evaluative credibilty of the persuader. This depends considerably on how the individual understands the relationship between their performance and the outcome (or consequence). If they feel personally responsible for the failure, then they will tend to blame themselves.

1.4.4 PHYSIOLOGICAL INFORMATION : Visceral arousal in stressful and taxing situations can often be interpreted as a sign of vulnerability to failure. Arousal can also be interpreted by some as facilitating performance. Cognitive evaluation of arousal occurs and leads to either a positive or a negative effect on self-efficacy. High achievers generally consider arousal as a facilitator; low achievers regard it as a debilitator (Hollandsworth et al, 1979).

Often it is the level of arousal that varies between situations that affects judgements, especially since an optimal level of emotion is required to enhance performance. Judgements of arousal can vary depending on a number of factors, including appraisal of the sources of arousal, the circumstances under which arousal is elicited, the level of activation and the past experiences on how arousal has affected performance. Cognitive processing of

emotional reactivity can regard the response as a sign of inadequacy or as a common transitory reaction of competence. Perceived self-efficacy can be viewed as one of the indicants of coping self-efficacy (Bandura, 1986).

1.4.5 SUMMARY : Bandura (1980) draws our attention to these sources of information because of their important role in the formation of peoples' self percepts of generalizable abilities, as guides for their behaviour. It is interesting when this occurs without the person being involved in mastery experiences. Judgements of self-efficacy can be made and developed without the direct experience provided during performance of a task. Generally, the sources of information are inter-connected in a complex array affecting our developing self knowledge. In forming their efficacy judgements, people have to deal not only with different configurations of information relevant to the task, but they also have to weigh and integrate efficacy information from these diverse sources. Clearly, any form of acquisition occurs in a complex reciprocally deterministic causal system.

1.5 PERFORMANCE and PERSEVERANCE

Self-efficacy is proposed to account for the persistence and effort in performance (Kazdin, 1978). Feeling capable of performing a task relates to the level of self-efficacy. The level of self-efficacy is the comparative component of the construct. An individual can feel more efficacious about some tasks than others, and may

be more or less efficacious than another person on a certain task. Persistence (strength) is determined over time. The stronger the percieved self-efficacy the more active are the coping efforts (Bandura & Adams, 1977). Strength of self-efficacy can vary and be affected through storing information derived from any of the above mentioned sources.

An ability to formulate an efficacy judgement especially when based on performance accomplishments will be influenced by appraisal of task difficulty, amount of situational aid, magnitude of effort, and the temporal pattern of successes and failures (Bandura, 1978). If an individual has previously experienced failure on a given task they may well lack the confidence to tackle a similar task again. Bandura (1978) describes two different expectancy sources of futility that contribute to a low persistence on a task.

1. People doubt their ability to achieve a required performance or they cannot produce what is required. This is a self-efficacy judgement.
2. Performances go unrewarded, therefore, they expect that their responses will go unrewarded. This effects their outcome expectations.

Individual's establish their own criteria of strength for their self-efficacy judgements. Perseverence is specific to each individual. Even though they may rate their self-efficacy as low compared to another person on the same task, they may still demonstrate a similar behavioural performance.

Judgements of self-efficacy are not experienced in temporal isolation. They occur in complex social and emotional situations, which all together, impinge on how an individual appraises the situation. Sometimes people can have the skills to perform a task but due to their emotional arousal, their effective competency is undermined. They often continue to make decisions about their course of action whether they attempt or continue what they have undertaken (Bandura, 1980). Overcoming hinderances is a test of an individual's strength of self-efficacy. In fact, Bandura (1980) argues that such self-efficacy judgements determine the nature of the individual's coping behaviour.

Attributions of performance can be recognised as internally or externally motivated.

> " Attributions for success that are external, specific and unstable will lead to lower efficacy expectancies than internal, global, stable attributions of success " (Goldfried & Robins, 1982, p366).

Therefore, successful performance may not enhance one's sense of confidence in similar situations, that is, it may not generalise. Environmental events and action occur in contingent relation to each other. Self observation and recognition of one's causal efficacy enables children and adults to experience control over their environment. The crucial linch-pin of this analysis is that actions must be perceived as part of oneself (Bandura, 1986). This process begins at infancy and continues throughout our lifetime.

1.7 MICROANALYTIC PROCEDURES

Microanalytic procedures attempt to monitor the relationship between thought and action. Proximal thought probes are used to support a covariate relationship between thought and behaviour. If we can establish indications of performance being related to self-judged capabilities then the thought probes will help explain and predict subsequent behaviour. The resulting information obtained from the thought probes correspond to the activities people will be called upon to perform.

To measure self-efficacy an individual is presented with a series of tasks that vary in difficulty, complexity, stressfulness, or some other dimension being explored. They designate the tasks they can do and the degree of certainty that they can execute them. A person's beliefs will affect how they behave, whether they rise to a challenge, intensify their efforts , demonstrate minimal stress reactions, or if they give-up easily.

> " Self-percepts of efficacy thus contribute significantly to performance attainments rather than serve merely as forecasters of behaviours to come " (Bandura, 1984, p242).

If there is to be a precise link between self-efficacy judgements and action, this will be provided by the degree of congruence between these two sets of factors on individual tasks (Bandura, 1980).

Further research and analysis of self-efficacy, and

its role in behaviour change requires, not only precision, but also a thorough regard for the verbal report. Due to valid criticisms of verbal report procedures (Nisbett & Wilson, 1977; Wilson, Hull & Johnson, 1978), further information regarding the change process is required to validate the phenomenology of social motivation. That is, current conscious thoughts regarding individual activity, reported during behavioural performance, need to be compared with retrospective explanations of the same behaviour. If conscious thoughts are theoretically inaccessible, then certainly there is no way of verifying unconscious thoughts.

The issue of, who is aware of what, is not easily resolvable. Smith and Miller (1978) sum-up the matter well when they conclude, that the more fruitful line of inquiry is not whether self-efficacy can ever reflect thought processes but under what conditions will they do so. Awareness of stimuli, or the cognitive process meant to be initiated by manipulations, may not occur for the subject. It is also possible to have behavioural changes that occur in the absence of verbal reports or changes in behaviour that are stronger and more reliable than verbal reports (Brody, 1980).

The analyses of causal cognitions must assess the thoughts occurring before or while actions are being performed. Direct probes of what people are thinking during an experience tap the cognitions to which they have access. Retrospective probes require them to speculate about their

performances of past behaviour. Such conjecture may bear little resemblance to the thoughts they experienced during the task performance.

Wilson et al (1978) suggest four independent dimensions of psychological processes that function during verbal reports :

1. those which are accessible to awareness and which determine the contents of verbal reports, but are not the critical determinants of the phenomena;
2. those that are accessible to awareness and which determine the contents of verbal report and are critical determinants of the phenomena;
3. those which are the critical determinants of a phenomenon but are not in awareness and are not the subject of verbal reports.
4. those which are the critical determinants of a phenomena and are in awareness and are not the subject of verbal reports.

Certainly the best measure of behaviour is performance, rather than reports about it, though Bandura has argued that thought probes provide a rich source of information for revealing cognitive processes and their functional relating for action (Bandura, 1986). The explanatory and predictive power of cognitive factors have become important indicants of change to the therapist and the client.

1.8 SUPPORT FOR THE SELF-EFFICACY CONSTRUCT

Support for the construct of self-efficacy has centred

round the assessment of it in relation to individual therapeutic change. Initially Bandura began the evaluation of his self-efficacy mechanism by studying phobic/anxiety responses of people to feared objects or situations. With the developing interest in the theory further extensions have been made to the research focus. The domain of social competence has gathered increasing interest (Goldfried & Robins, 1982; Kanfer & Zeiss, 1983; Kazdin, 1979; Moe & Zeiss, 1982).

Bandura (1978) lists numerous studies using microanalytic procedures to demonstrate that antecedent cognitions are excellent predictors of observational learning, operant conditioning, conceptual learning, persistence on achievement tasks and behavioural change accompanying diverse modes of treatment. Goldfried and Robins (1982) also list self-efficacy research that focuses on achievment behaviour (Brown & Inouye, 1978; Schunk, 1984a), assertiveness (Kazdin, 1979), smoking cessation (Condiotte and Lichenstein, 1980), physical stamina (Weinberg, Gould, and Jackson, 1979), and recovery from heart attack (Ewart, Taylor and DeBusk, 1980). The experimentation encompasses a wide variety of activities performed by children and adults from different walks of life.

Bandura and Adams (1977) demonstrate the difference in individual therapeutic change by comparing three groups of snake phobics and their treatment modalities. Each group was subject to different sources of information :

a). participant modelling - engaging in progressively more threatening experiences with a boa constictor;
b). modelling treatment - vicarious learning;
c). control condition - where no intervention was administered.
The lives of the subjects had been adversely effected by their fears, though there were different modes of change with varied outcomes. Bandura and colleagues postulate that their is a 'common cognitive mechanism' that explains and predicts performance post-intervention or therapy.
Self-efficacy was measured at critical junctures during the experiment. Bandura, Adams and Beyer (1977) confirmed that different treatment approaches altered expectations of personal efficacy, and the more dependable the source of efficacy information, the greater are the changes in self-efficacy. Following complete desensitisation, self-efficacy was shown to be a highly accurate predictor of the degree of behavioural change.

Bandura, Adams, Hardy and Howells (1980) looked at testing the generality of the theory across additional treatment modalities and different behavioural domains. This was a more stringent test of the theory, to examine the links between environmental influences, indicants of the critical mediating process, and action. Judgement of personal efficacy is an inferential process. Personal and situational factors they influence performance successes and failures must be weighted.

Bandura et al (1980) confirmed that self-percepts of efficacy, whether produced enactively, vicariously,

emotively or cognitively, predict not only the level of behavioural change resulting from different modes of treatment, but variations in coping behaviour by individuals receiving the same type of treatment and even specific performance attainments by individuals on different tasks. People who believe they can exercise some control over aversive events display less autonomic arousal and performance impairment than those who believe they lack personal control, even though they are all subjected to the same aversive stimulation.

In these diverse lines of research, predictive success is achieved across time, settings, performance variants, expressive modalities and vastly different domains of functioning. Measures of self-percepts of efficacy using the microanalytic approach predict variations in level of changes produced by different modes of influence, variations amoung persons receiving the same mode of influence and even variations within individuals with regard to the particular tasks they are likely to master or fail (Bandura, 1977; Bandura et al, 1980).

Results from such varied research infer some important consideration for the therapist in enhancing a clients cognitive processing of experience. Goldfried and Robins (1982) have noted five points that are worth mentioning :

1. discrimination between past and present;
2. adding objective outlook to the clients subjective vantage point;
3. retrieval of past successes;

4. aligning expectancies, anticipatory feelings, behaviours, objective consequences and self-evaluation;
5. experiencing the 'cognitive click' when the person experiences something happening during therapy. They begin to reconstruct the image of themselves.

Individuals with a personal and/or professional experience of psychotherapy and behaviour change are impressed with the incredible number of techniques that claim to induce therapeutic change. Self-efficacy accounts for the effects of therapy using one unifying mechanism of explanation. This is important, according to Kazdin (1978) for two reasons :
1) it has fostered a great deal of research rather than trying to explain change through different techniques, and
2) self-efficacy has been proposed in a way that encourages further investigation.

1.10 CRITICISM

Criticism of Bandura's work has focused on either the conceptual inferences of the theory or the methodology developed to assess the construct. Eastman and Marzillier (1984) suggest that self-efficacy is not conceptually distinct because outcome expectations also play a significant role in the change process. They believe that Bandura has not clarified this problem and interpretation remains ambiguous. Borkovec (1978, p166) admitted to

> "...some difficulty in understanding exactly what Bandura means by efficacy expectations and outcome expectations ".

Eastman and Marzillier (1984) have described what they consider the central core of this conceptual problem to be; outcomes are inextricably bound up with the task to perform. Appraisal cannot be exempt from consideration of outcome and often the outcome is the incentive for behaving in a given fashion.

However, the self-efficacy construct has been well defined by Bandura. The conceptual difficulty experienced by some critics emphasises an important issue that requires clarification. One can never sever expected outcomes from the very performance judgements upon which they are conditional. Distinguishing between the source of outcome expectations and their role in regulating behaviour is essential. Action that is based on self-appraisal of efficacy is far more beneficial to the individual than action without prior consideration to the individual's capabilities. Bandura (1984) asserts that behaviour is partly guided by forethought and that peoples judgements of their capabilities are pervasive in their appraisal of situations. An individual's history of past outcomes influences their assessment of self-efficacy in coping with a new situation. They weigh-up, or judge, whether they will or will not be able to accomplish a specific task.

Furthermore, it seems unclear to Eastman and Marzillier (1984) what is being studied during the self-report microanalysis. It is possible that the scale measures

something other than what it is proported to measure. They suggest that Bandura's studies with snake phobic subjects may be effected by pre-test behavioural assessment of the avoidance behaviour. They argue that the essense of self-efficacy may be a rational appraisal of one's likely future behaviour based on previous knowledge. This query does not address the difference between results from the 'performance' treatment group and the 'observing' treatment group. The construct of self-efficacy is still valid even if the individual subject has a past history of experience that they can use as a baseline to measure their performance capabilities.

Two semantic issues they raise are whether the verbal labels are equivalent and whether the mid-point of the scale is conceptually equi-distant from the poles. It is also possible that the ratings of confidence required as the self-efficacy measure might not be probability ratings. Bandura's considers these trivial issues. A self-efficacy measuring device requires the subject to complete two judgements that are simple and straightforward. First, they judge whether or not they can accomplish a given performance, and second, for those items they judge they can do, they rate the strength of their perceived efficacy. The scale, for strength, begins at 10 because the subject has already answered the first question stating that they can complete a task. Probability ratings are supported by three aspects of the analysis. Firstly, correlations between aggregate scores of efficacy judgements and performance attainments are established. Secondly, the

degree of congruence between self-efficacy judgements and action is gauged by recording a cut-off strength value and comparing the percentage of correspondence between this and the actual performance on individual tasks. Thirdly, discovering the probability of congruence between successful performance and recorded strength of perceived self-efficacy.

Smedslund (1978) argues that any valid theoretical statements in psychology are explications of conceptual relationships imbedded in ordinary language (common-sense). This common-sense theorem proposes that ordinary language is constructed in a logical manner such that propositions, like self-efficacy, are implicitly supported.

> " Becoming socialised as a human being, therefore involves acquiring an implicit psychology, which one cannot, as an individual, transcend "(p11).

However, Bandura claims that any logical analysis does not reveal the exact function between the variables in question. He distinguishes between the elimination of erroneous reasoning, provided by logical analysis, and the establishment of factual accuracy, provided by experimentation and questioning the validity of propositions. Bandura comments that one can have logical relationships between propositions that are contrary to observable fact. A good example of this phenomena is, the misleading common-sense notion that is widely held to be true, until it is questioned and tested. Logical analysis provides a means of eliminating erroneous reasoning, but it is not sufficient to establish factual accuracy. It is important to distinguish between the logical analysis of

the internal structure of the theory and the empirical analysis of the adequacy of a theory to predict the events with which it deals. Different consequences are hypothesised by different theoretical propositions. One determines how well a theory stands up under systematic observation, and compares it with other conceptions.

Eysenck (1978) examines the conceptual and methodological issues raised by self-efficacy theory. His essential criticism is that he believes that Bandura has failed to deal with alternative, non-cognitive theories. The paradox at the beginning of Bandura's theory is that modern theories of behaviour change tend to be cognitive in nature, while the methods which actually produce such behaviour change are performance based. In Eysenck's view, cognitive theorists reject non-cognitive theories for no good experimental reason and they associate with cognitive views in the absence of good experimental evidence. Eysenck concludes that Bandura presents an interesting alternative to classical theories and their more recent modifications. However, Eysenck believes that Bandura has not addressed the crucial question of the causal role of self-efficacy and other cognitive events in the path of change.

The causal role of self-efficacy is an important issue of criticism for Bandura and colleagues. Poser (1978) supports Bandura's claim that verbal reports predict later performance, but disagrees with Bandura's statements regarding self-confidence 'causing' the behavioural change. Self-efficacy expectations, he says, are considered both

process and dependent variables, that is, a behaviour change procedure enhances self-efficacy, and the later, in turn, produces behaviour change.

Comments by Eysenck are dated in the light of Bandura's latest publication, Social Foundations of Thought and Action. A more detailed analysis of contributing cognitive theories is provided. This is important for the establishment of the self-efficacy construct and measurement of it, to be extended and varified. Bandura supports behavioural explanations of phenomena, but it is the role of cognitive factors in experience that he attempts to investigate and measure. Self-efficacy is not separate from the rest of human functioning, but is part of the integrated reciprocal deterministic chain. Reciprocal refers to the mutual action between causal factors (Bandura, 1986). The production of effects by certain factors signifies the deterministic character of the chain. Often many factors are needed to create a given effect.

Criticism of Bandura's theory of self-efficacy has been fruitful. It has developed our understanding of the complex nature of the role of cognitive variables in human agency. For instance, Sappington et al (1981) proposed a four variable model to explain the function of intellectual and emotional self-efficacy and outcome expectations. They argue that behaviour is a function of intellectually and emotionally based versions of both self-efficacy and response-outcome expectancies. The intellectual self-perceptions are accurate, whereas the emotionally based expectancies are beliefs that have an 'as if'

quality. They are not necessarily perceived as accurate.

These two different types of expectancy respond to different variables. Intellectually based expectancies are manipulated by providing new information; emotionally based expectancies are manipulated by varying the emotional context in which the information is presented. They conclude with supporting evidence for Bandura's claim that self-efficacy expectancies predict future performance. However, they add that response-outcome expectancies also predict avoidance behaviour. It is not clear what aspects of cognitive appraisal are acting in the modification of behaviour. Further clarification may support the use of different therapies to gain the maximal effect.

Moe and Zeiss (1982) support the implications for clinical application such as targeting areas for modification and the development of individual hierachies for facilitating the change process. Self-efficacy and its measurement may assist in therapeutic tailoring of treatment (Sherer et al., 1982). Efficacy reports account for the combined influence of past history, current environment and current behaviour; they undoubtedly reflect the change process (Borkovec, 1978). If social learning theory and self-efficacy belong to a school of thought let us not accept it like it was a form of catechism to be recited by good pupils, but rather, question and refine its parameters.

SECTION (B) : INPATIENT UNITS

> " Nice, successful people who have a good marriage often have trouble raising children. And unfortunately, people who are shits often have no trouble with their kids at all " (Gross, 1978, p248).

1.11 INTRODUCTION

The purpose of this section of the literature review is to provide a foundation and rationale for self-efficacy research in an inpatient child and family psychiatric unit. Some of the important issues to consider are : (1) the historical background of child psychiatry; (2) characteristics of inpatient units; (3) the role of the family in therapy and treatment; (4) the advantages and disadvantages of inpatient versus outpatient treatment. A brief overview of child psychiatry and treatment procedures suggests the need for further research, especially in the field of inpatient treatment of children and families.

Current research suggests that psychotherapy remains predominantly individual as a mode of treatment for children and adult psychiatric problems (Silver and Silver, 1983), and it is predominantly long-term in duration (McDermott, 1984). Treatment of children and families favours combining hospital and community involvement (Barker, 1974; Barker, 1976; Harbin, 1982; Hersov & Bentovim, 1985). The community involvement includes child guidance clinics, community agencies and other services concerned with children in need. Treatment is aimed to be

specialised rather than the same for all children (Barker, 1974; Blinder et al., 1978; Shafii et al., 1979).

Strupp & Hadley (1977) have described three parties that are interested in the evaluation of human functioning:

a) society - (and significant persons in the patient's life),
b) the individual patient, and
c) mental health professionals.

Society and significant others tend to evaluate human functioning by considering the normalisation of the behaviour. Behavioural stability, predictabilty, conformity to a social code are the concerns of the society that wants to maintain an orderly world. The individual patient considers it important to focus on their subjective well-being and how a general feeling of discomfort motivates a person toward treatment. Mental health professionals often view functioning in terms of an individual's - dynamics, structure of the child's personality, drives, self-orientation and various other explanations describing internal pathology. The inpatient treatment situation is no exception; it incorporates all three in its role.

1.12 HISTORICAL DEVELOPMENTS

The modern approach to psychiatry, and child inpatient psychiatry in particular, has made significant changes in the orientation towards human problems. Romanczyk et al

(1979) document the habits of the early Greeks, who left 'imperfect' infants to die in the forest. The current methods of dealing with social and individual problems are aptly characterised by the development of individualised treatment programs for adults and children. Previous to this there was an emphasis on custodial or 'correctional' methods rather than the adopting of therapeutic approaches. Group care for homeless children occurred in asylums and reformatories (Palmer, 1983). The advent of 'moral' treatment in the 19th century introduced a more humanistic approach to care.

Inpatient psychiatric units for children began in the early 1920's in the United States, due to the large number of children with behaviour disorders following the epidemic of encephalitis lethargica (Barker, 1974; Chess, 1969; Hersov & Bentovim, 1972 ; Hersov & Bentovim, 1985). These children could not be treated as outpatients and the plan was to 'contain' the problems by care and management. In Britain, hospital inpatient units for children were established after World War II (Barker, 1974) as such a service became the treatment of choice, strengthening the relationship between psychiatry and pediatrics. In-residence treatment for children with psychiatric disorders had been the tradition in Britain since the 1930's, but this had occurred in non-hospital educational units. This environment provided an apprropriate atmosphere for emotional and social development (Laslett, 1975).

With the increase in the use of pharmocologic treatment

and the emphasis on community support and accomodation for mental health patient's, the structure of these units has slowly changed. The reduction of the population of most public hospitals has produced a concomitant rise in the number of brief stay admissions (Harbin, 1982). Consequently, therapeutic programs have been designed to function during a brief intervention period.

Short-term care can mean relief from a critical family situation, with the child returning after the tension has subsided. Unless parents are involved in the therapeutic process then inpatient treatment may not be effective in returning the child to the community and home. Use of family therapy tends to lessen recidivism and enhance community adjustment (Ro-Trock et al, 1977). It is also important that the inpatient unit is in a working relationship with the outpatient services, community agencies or child guidance clinics concerned with children in need (Blinder et al, 1978; Shafii et al, 1979). When initiating treatment it is important to establish realistic goals, that can be ideally achieved within the constraints of the institution.

Robinson (1947) described three types of units and their functions. Firstly, some tend to emphasise the importance of diagnosis and research, attempting to control the environment using the inpatient facility. Secondly, educative therapy helps the child make the best use of the residential setting and psychiatric work centres around skills in the living situation. Thirdly, some units

function to facilitate and enable children to participate in psychotherapy with the residence function being secondary. Even though this paper was written about 40 years ago, it still remains relevant. Noshpitz (1962) also writes about some of the basic aims of units ranging from supporting the child while they experience psychotherapy to providing a warm, supportive, living environment. Emphasis is often being placed on group relationships in the unit (Rioch & Stanton, 1953).

Two important traditions have developed since the turn of the century with the tremendous growth rate of child guidance clinics (1900-1950). Firstly, the tridisciplinary collaboration of psychiatry, psychology and social work and secondly, program evaluation (Barrett et al, 1978). Research in the child guidance domain is relatively small in comparison to the whole field of psychotherapy and behaviour change. Evaluation is necessary to continue refining and developing child and family psychiatric practice.

The child guidance domain experienced two important pieces of work that opened up the area for criticism. Witmer (1935) completed a detailed demographic evaluation and Levitt (1957, 1963) reported a significant series of studies evaluating child psychotherapy. In both cases these forms of macrovariable research continue to demonstrate that 70% of disturbed children improve with psychotherapy or time alone. Heinecke and Strassman (1975) have pointed out that the second most researched aspect of child therapy

after the child guidance practice, is play therapy.

Bartlett (1978) suggests that we need to refine measures in four areas :

1).the child and the disorder,

2).therapist and personality,

3).intervention techniques,

4).outcome measures.

This research departs from these issues in that the primary focus is on the parents who are often not evaluated in the change process.

1.13 RECENT TRENDS

The trend in the development of services has moved from the traditional, psychodynamic approaches toward more biologically and behaviourally based treatment formats. This is clearly reflected in two recent summaries of criteria for successful conclusion to treatment. Moss & Boren (1971) and Moss & Levine (1980) have listed the important criteria for adult and child treatment success. They are :

a) description of the problem behaviour,

b) specification of treatment goals,

c) description of a patient's current effective repertoire of skills and attainments,

d) specification of the therapeutic methods to be used to achieve treatment goals,

e) a system of measurement over time to assess the

direction and magnitude of change in response to treatment.

The changes in the assessment and treatment of childrens' problems has required dimensions of knowledge over and above the child's psychopathology (Sonis, 1967). An analysis of the child's family system or school environment and peer relationships are good examples of the type of breadth required. A closer look at the child's environment has become more important in order to bring about therapeutic change, because environmental factors contribute to the maintenance of problem behaviours (Epstein & Vlok, 1981). Shorter terms of treatment return the child to the home environment much earlier than custodial care. Whatever the etiology of the disturbing behaviour it is usually the case that the family or community can not tolerate the problems, and in the same instance, are involved in the explanation and description of them. Usually children are in therapy, not because of the absence of educational efforts, but because repeated educational efforts have failed (Kaplan & Sadock, 1985).

Problems experienced by children are usually only recognised and responded to if they impinge on the social system, whether this is by way of a symptom, a ward behaviour problem, or sufficient family problems (Sack & Blocker, 1978-79). Child psychotherapy, therefore, is part of a larger field including such issues as parenting, child advocacy, development, education and adult maturity. Research in this area cannot remain independent of the evaluation of the family and the larger community

(Bartlett, 1978). It is important, then, to consider the continuing development of research in child psychotherapy and incorporate a meaningful foundation for further research.

Heinecke and Strassman (1975) have discussed five important issues to consider in the research in child psychopathology.

1.Abandon 'does child psychotherapy work?' for what therapy, under what conditions, for which patients with which disorder yields results'?

2.Systematic attention to the developmental status of the child.

3.Investigation of limited but theoretically meaningful variables such as psychotherapy equivalent of 'dosage' (e.g.frequency of sessions and duration of treatment).

4.Systematic attention to 'parental' impact, age, variations in therapist characteristics, to mention but a few.

5.Development of instruments that permit more specific outcome assessment (e.g. Revised Behaviour Problem Checklist).

Recent research has provided support for individualised treatment programs rather than the same treatment for all problems (Hersov & Bentovim, 1985).

If the environment is going to be used for therapeutic change then there are many factors that should be considered.

1. Staff and parent involvement in treatment.

2. Attitudes and prejudice in behaviour change.
3. The structure and content of the child's treatment.
4. The expectations and opportunities provided by the milieu situation.
5. Emphasis on various techniques in the programme, especially the objectives and role of individual psychotherapy, family therapy and behavioural therapy.

Such a thorough breakdown of the behaviour change process has superseded the previous system of providing a benign neutral setting to offset the adverse family influences that get in the way of psychotherapy (Berlin, 1978 ; Schulman & Irwin, 1982).

Furthermore, the treatment procedures initially developed from the outpatient practice of the time were characterised by the multidisciplinary clinical team approach. Though this has remained an important part of more recent units, the identity of inpatient child psychiatry has developed its own characteristics to account for the significant differences between inpatient and outpatient care. Unlike adult psychiatry, child inpatient psychiatry developed from an outpatient service, which is the complete reverse (Barker, 1974).

1.14 ADMISSIONS AND AIMS

Due to the often persistent pressure from agencies or parents to admit the child it is crucial that powerful efforts are made to keep the child and family in 'psychological touch' (Hersov & Bentovim, 1985). Inpatient

treatment is but an episode in the course of treatment, even if it is a prolonged one (Barker, 1974). Inpatient treatment could be described as an instrument in an orchestra. To evaluate its role would mean removing it from the whole, rather than considering it in combination with other instruments. Inpatient psychiatric treatment and therapy of children and families is not meant to be a solo performance.

Reasons for admission are numerous and varied. Clarification is important because the admission to hospital is one phase in the overall treatment plan. Some of th possible reasons for admission could be : the child has demonstrated that they cannot function in a less restrictive environment; there is a potential danger to the child or others because of the behaviour (e.g. fire setting, suicide, self abuse); intensive evaluation is required in a controlled setting; an attempt to bring about a substantial change in the child's personality growth and development; the treatment of serious psychotic disorders or the presense of a life threatening illness (Barker, 1974; Moss & Levine, 1980).

Due to the increase in family involvement in treatment, broader issues are being considered in the decisions made regarding admission of the child and the family. Nakhla et al (1969) have described the rationale and advantages of taking the total family into hospital where the setting is a appropriate for this method of treatment. Certainly, there are reasons beyond the specific child that cause

admission. For instance, the family structure may be distorted, parents need to work through the consequences of experiencing an emotionally disturbed child, for families to alter their behaviour, and that which is often the case, outpatient treatment has proceeded for considerable time without appreciable success (Hildebrand et al, 1981; Wilinson, 1983).

There are some clear advantages to hospital admission:
1. the family has a chance to recuperate and learn new methods of functioning;
2. the child has a chance to modify his/her behaviour and benefit from new experiences, rather than remaining part of the pathological interactions of the family;
3. an additional lever is created that helps the therapist involve the family in the process of therapy;
4. the family reaction to the temporary removal of the child from the system can provide an imbalance that can be used therapeutically in the reorganisation of the family. In either case, the therapist uses the family's reaction to promote change;
5. spiritual and political values can be better developed than in a day setting;
6. skills in handling authority figures are developed.

There are also some disadvantages to hospitalisation :
(a) the family cannot fully work on its problems and explore possible solutions;
(b) the family is more likely to become dependent on therapists because of the intense contact;

(c) the child is living in an artificial environment, away from his/her family, school and peers;
(d) the time limited of the program;
(e) the danger that the community and the family will fail to develop a relationship beyond the referral source.

This short synopsis of the advantages and disadvantages are an example from two sources - Barker (1974) and Hersov and Bentovim (1985). Disadvantages reflect some of the issues that can be offset by intelligent and conscientious planning.

1.15 THEORETICAL MODELS INFLUENTIAL IN THE FIELD

Characteristics of inpatient units have changed over the years according the theoretical influences in the field. In the early 1900's residential treatment of the child was commonplace and tended to focus on providing a planned environment for delinquent and emotionally disturbed children. Robinson (1957) defined an inpatient treatment unit as a psychiatric service in a medical institution or unit. Such units where characterised by a clearly hierachical system with the consultant psychiatrist having the final responsibility (Barker, 1974).

Multi-disciplinary services have often been characterised by ideological conflict, with a fragmentation of services usually occurring in response to this. Some mental health professionals view problems as chiefly biological or intrapsychic in origin and others see the

cause as coming from dysfunctions in the larger social structure (Harbin, 1982).

Models and programs of units tend to be influenced by either of the four main theoretical orientations underlying the bulk of child psychotherapy.

1. Psychoanalytic - evolution and resolution of emotional disturbance.
2. Social-Learning-Behavioural theories.
3. Family systems-oriented transactional theories of pathology and treatment.
4. Developmental theories.

In practice the blending of theory and design requires a sensitive organisation of the various disciplines. The treatment team may be made up of social workers, psychologists and psychiatrists, teachers and administrative staff. With such a combination of disciplines it would be likely that interpersonal conflicts and disputes, over roles and procedures, would occur (Hersov & Bentovim, 1985; Kaplan & Sadock, 1985; Wilking, 1974; Williams, 1983). Often treatment involves the whole staff of the unit, not just the individual therapist. Therefore, treatment can include input froma variety of theoretical disciplines.

Individual staff differ in their style and perception of the child's and family's problem and needs. Establishing a unit with unified staff is a priority (Lansky, 1977).

Consultation between staff is important in co-ordinating the child and family program. For instance, the child-life therapy program (Sack & Blocker, 1978-79), reduced consultation time for the ward psychiatrist enabling her to interact with the children and families more often.

Initially it is important that an overall environmental design for the programme is established and is the step to bridging the gap between theory and practice (Cotton & Geraty, 1984; Wilson, 1977). The individual staff preferences can be expressed in the recommendations for the ward set-up (e.g.use of a play-therapy room). Differences in theoretical models can have the influence on the physical parameters of the ward, thereby supporting and facilitating clinical goals. For instance, the establishing of a time-out room or facility for whole families to live in the ward.

Broadly, units depend on the philosophy of the psychiatrist who is in charge, to direct their involvement with the child and family (Frommer, 1972). However, the various sub-specialities working as a team need to function in collaboration to enhance the successfulness of the ward program (Williams, 1983). Coordination on a daily basis is essential to the progess of the therapeutic input for the child (Moss & Levine, 1980).

Whenever a variety of treatment modalities are simultaneously employed there is a danger that they impede rather than enhance one another (Schween & Gralnick, 1966).

Whether there is a combination of these modalities, or one, it is difficult to evaluate which is effecting the change. Kaplan and Sadock (1985) stress the importance of evaluation of the therapy process. Due to the nature of the child inpatient unit (expensive, demanding and time consuming) the facility requires evaluation of its effectiveness. No matter how different the facilities may seem, similar threads run through most places and there is always a need to share ideas on programs that have been successful (Wilson, 1977).

A diversified activity programme in a milieu therapy environment requires the skill of the the child care workers. Programming daily activities demands that the worker keeps one eye on each child's therapeutic 'game plan' and the other on the whole group (needs and skill-levels). Play is important in the milieu structure, it enhances ego repair and change (Redl & Wineman, 1952). The overall design of the structure becomes

> "...a built in structure contributing to the healthy growth of the children " (Wilson, 1977, p250).

Wilson (1977) suggests that the program that he has been involved in has reinforced the view that the best way to deal with crisis is by trying to structure the environment to prevent them.

Emphasis on the environment in treatment has increased since the development of social-bevavioural theories and practice. In fact, recently the development of psychiatric units has incorporated the liaison between clinical and

engineering disciplines. Translating clinial theory into architectural working plans is a challenging task.

> " Design details articulate treatment goals " (Cotton & Geraty, 1984, p628).

They also comment that children, the focus of treatment, are susceptible to the messages of physical space. Hersov and Bentovim (1985) describe a milieu (or therapeutic community) as the practice of shaping and controlling the setting for a group of children, and the emphasis is on constructing the dimensions of daily life. Such characteristics of the inpatient ward structure, organisation and setting can help reduce emotional and behavioural symptoms. In general, the milieu structure is common for all children.

However, the development of family systems theories to account for presenting problems and creating methods of intervention, has emphasised the role of the 'family' more than ever before.

NB.The family approach and family management, however, are not the same as family therapy. The admission of a child to the hospital defines him/her as the locus of pathology. This illogicalty of singling out one family member when the orientation is proported to be systemic family therapy, has not yet been resolved. This may not be possible, but consideration of alternatives is an important part of change. Recently there has been an increase in reports of family oriented units, their existence and evaluation (Harbin, 1982; Hildebrand et al, 1981).

They report that their is a paucity of literature referring to family-oriented children's inpatient units. Some of the important issues that they address are : the essential value of committed staff to family intervention; staff supervision and support is crucial; the optimal length of admission (Hildebrand and colleagues chose three months as their maximum period); follow-up after treatment is less intensive and may be unsatisfactory for families with complex problems; and what sort of families and children would be best suited to such a setting? They conclude that whatever the presenting problem, it is important that the therapist use his/her authority to define and implement rules of therapy. This will enhance his/her expertise and benefit the families he/she treats.

Furthermore, Harbin et al ((1979) emphasise the important role of the workers interacting with the child and family on a regular daily basis. Observation during visiting hours provides examples of informal interactions between family members and nursing staff. Training of these staff members so that they understand family dynamics and treatment was underlined in their evaluation. This meant that they could participate in the specific treatment of the child, as well as facilitating the milieu environment.

1.14 TREATMENT PLANNING

Though long-term treatment for children has lessened considerably in the last twenty years

> "... it is still not uncommon for short-term therapy to be looked upon as a second-rate service " (Dulcan, 1984, p544).

It is often believed that short-term therapy is completed after intervention. This is not the purpose or theoretical function of this approach. It is a misnomer to believe that short-term intervention does not continue after hospitalisation. Theoretically, and practically , the child and family should move from inpatient treatment and support to an outpatient facility for continuing help.

One of the strengths of child and family short-term inpatient treatment is that maximum activity and participation are required for the program to function (Dulcan, 1984). Safer (1966) described a good outcome in therapy being the parents willingness to see their child's symptoms as an indication of a family problem or the presence of a new precipitant (i.e.external stress, developmental stage). Often part of the process of therapy involves the reframing of the child's presenting problem so that the family are incorporated within the micro-system of the ward program. Remembering that one of the primary aims of inpatient treatment is to reunite the child and family, and return the child to normal life in school and community. Early intervention in child psychiatric problems is critical to the prevention of a more serious mental health puzzle. Maintaining the family as a healthy cohesive

unit is incorporated into the philosophy of treatment (Hildebrand et al., 1981; Harbin, 1979; Ney, 1985).

Looney (1984) suggests that the treatment planning step between diagnosis, explanation of the problem and treatment, requires renewed attention. There are some important issues to consider to maximise a healthy outcome and match an appropriate treatment package to the kaleidoscope of problems. The type of treatment is difficult to plan due to the multi-determined psychological disturbances in children and the varied approaches to etiology of disorders. Consideration of the intensity and duration of psychotherapy (the dose) and the environmental considerations need to be taken into account in treatment planning, thus emphasising parent and school involvement in the program (Rutter, 1982).

Once psychotherapy has commenced the child and family experience the steps incorporated in the structure of a program. It is possible to distinguish stages of change during a therapeutic program. McDermott and Char (1984) have suggested a stage-related model of psychotherapy with children :- (1) establishing a working relationship; (2) analysis of its problem and cause; (3) explanation of the problem; and (4) establishing and implementing the formula for change and termination. Due to the shorter nature of the inpatient program, it is even more important that the family is engaged as quickly as possible, and especially the parents or guardians, who will maintain any changes that are achieved during the program. This is even more

important to acknowledge when we consider how powerful some psychological techniques can be. Such powerful tools of change can also have the potential of making them worse (Griest, 1984). For example, one of the mistakes made during treatment is acting with insufficient information about the child's problem.

Intervention at an early age is extremely valuable when you consider the vulnerability of the child to medical, social, and emotional problems. Whatever the age of the child, the staff need to recognise age appropriate behaviour. It is quite possible that children experiencing the stress of hospitalisation act out some of their feelings. Often these vary according to their age. For instance, children under four years usually interpret separation from their parents as punishment or desertion; four-ten year olds experience anxiety and fear about the severity of their admission, and teenagers experience struggles to establish a sense of identity and independence, which can sometimes interfere with their cooperation in treatment programs (Kaplan & Sadock, 1985).

Sometimes a decision has to be made on what are the most important issues to be addressed, then staff have a more realistic task ahead of them. Planning of the child's treatment attempts, in theory, to take full advantage of the available assets in the child, family and community. Looney (1984) suggests that treatment planning is a differential process, selecting in order of priority between curative, ameliorative, corrective or palliative

approaches. Treatment planning, therefore, remains a significant step in the intervention process.

Another part of the treatment package involves the environment in which the patient is hospitalised. How the child is cared for is a critical factor in changing the way they feel about themselves (Terry et al, 1984). Social planning is frequently considered to be a vital part of designing a psychiatric treatment program (Wilson, 1977). Adult programs have been developed for their ward atmosphere, as perceived by the ward staff and patients, and the results have indicated that the treatment environment relates consistently to the treatment outcome (Moos et al, 1973; Price & Moos, 1975). Evaluation of treatment environments has highlighted some important factors:- autonomy, independence, practical orientation, order and organisation, open expression of feeling, as characteristics of effective environments. Steiner (1982) believes that patients also do much better when there is an evident high proportion of staff to patients on the ward. This increases the probability of staff-patient contact.

In order to bring about therapeutic change, many issues are considered : these include the attitudes of staff towards parents; the parents role in treatment, the therapeutic atmosphere in the unit, the overall daily routine, the structure and content of each child's treatment program, the expectations and opportunities provided by a group living situation, and the place and objectives of individual, dynamic or behavioural

psychotherapy.

If there is a discrepancy between expectation and reality it leads to premature treatment termination . Beitchman and Deilman (1983) suggest that there is an inverse relationship between severity of diagnosis and premature termination from hospitalised treatment. They consider inpatient treatment as a drastic method compared with outpatient treatment. However, the task seems to be to find the patient-treatment fit that provides optimum therapy and reduces their vulnerabilty to, what Beitchman and Deilman term, 'the defection quotient'. The best predictors of outcome during treatment are: hospitalisation, frequency of therapy, and patient characteristics, such as blue collar families, who are likely to terminate intensive therapy than families from other social classes. Beitchman and Deilman also state that when drastic treatment, such as hospitalisation, is provided for milder forms of disturbance, the children and their families discontinue treatment. Stocking (1972) suggests that the vicissitudes of hospitalisation effect considerably how the child and family handle the program. It may well be necessary to involve a familiar face in the treatment who is not involved with the psychotherapy experience (Sack & Blocker, 1978-79).

1.15 THE FAMILY APPROACH TO TREATMENT

Family involvement is essential to provide a continuity of approach and to ensure generalisation of

improved behaviour to situations at home and hospital (Shaffer, 1984). Parent's involvement in the treatment program enables them to develop skills in dealing with specific behavioural problems at home, therefore, complementing the hospital program. Dealing with families also involves consideration of the family system, especially since the introduction of family therapy and systems theory application to child problems.

Bingley (1980) has suggested that the effectiveness of a paediatric ward is enhanced by the involvement of the family, and clinical experience supports the contention that successful admissions have been those where the decision and motivation have come firmly from the family (Harbin, 1979; Hildebrand et al, 1981; Williams, 1978). Anderson (1977) recommends that a unit requires the cooperation of the family and the family requires the cooperation of the staff to solve the problems. Some of the issues that are important to consider are:

1. establish contact with the family (Hersov & Bentovim, 1985);
2. create a working climate (Moos et al, 1973; Price & Moos; 1975);
3. availability of staff for the family (Steiner, 1982);
4. regular family meetings;
5. variety of treatment formats;
6. adequate aftercare.

There is a growing concern that hospital care practices do not take into consideration the importance of the early

contacts between infants and parents. Hospital staff could be contributing to the onset of parent-child relationships that lead to the syndromes of battered child, failure and the vulnerable child (Kaplan & Sadock, 1985).

Admission of the child is often due to the parent's frustration and anger with their child, who they want to see changed (Kaplan & Sadock, 1985). This can often lead to the initial 'washing of hands' by the parents, consequently

> "...children commonly begin therapy involuntarily, often without the true benefit of parental support " (Kaplan & Sadock, 1985, p816).

They also believe that psychotherapy with children is characterised by the need for parental involvement.

There are varying degrees of parental involvement in child psychotherapy ranging from the entire therapy focused on parents (i.e.pre-school children, no direct treatment of the child) to the child on his/her own without parental involvement. The extent of involvement is determined partly by what the service offers and partly how motivated the parents are. The service can range from sometimes just an informational alliance to the therapeutic mobilisation of forces in the parents, children and family as a whole.

Wilkinson (1982) suggests three types of family involvement by professionals:
1. parental casework - family members are helped separately with traditional counselling and teaching the parents to handle the disorder of their child;

2. family casework - often involving the whole family, but more in relation to teaching of behavioural techniques in conjoint fashion;
3. family therapy - intention is to change the family as a whole.

Krajewski and Harbin (1982) describe three types of family involvement. Firstly, the overinvolved family who become enmeshed with the patient and often ward staff. Secondly, the underinvolved family whose motivation is generally directed towards increasing the distance between the family and the patient and staff. Thirdly, the psuedo-involved family presents as interested in the program and therapy, but is ambivalent when pushed. Though they do not mention the 'perfect' family in their summary, it is also possible that a family can cooperate appropriately when engaged in their therapy.

Engaging the family in the treatment is still a task requiring careful preparation. The staff have to tred carefully in approaching the family issues when such feelings are running high. Family involvement in the program becomes even more important and their needs are often viewed as the 'patient' (Mandelbaum, 1977). The trap of attempting to provide the child with better parenting through staff expertise and the structured ward program is always present. Parents can experience a sense of failure which is heightened if staff attempt to become psuedo-parents for the admitted child.

A family systems approach places parents in control of the child, thereby improving the parental coalition, assisting parents in restructuring generational and interpersonal boundaries and assisting parents in restructuring and enforcing major rules of the home (Safer, 1966). Efficacy of parent management is enhanced if intervention is also provided to reduce parental isolation and dysphoria and marital difficulties. The extent that parents are involved in the program is an important part of the evaluation process (Griest, 1984), especially since they play a significant role in maintenance of child and family changes.

Changes that take place during the ward program can occur through a variety of methods such as : discussion, modelling, participation, withdrawal, parenting the parents (Wilkinson, 1982). When viewing the child's symptoms from a systems perspective, the patient is presenting his behaviour as a symptom of a dysfunctional family and the elements within it. The patient is offered a new kind of relationship through individual therapy and the ward program rather than the distorted and anxiety-ridden relationship he/she has had with his/her parents.

Child inpatient treatment is a developing approach to numerous complicated social problems. Recently, the emphasis has been to involve the parents more in therapy. This implicates them in the change process. Parents involved in child management feel varying degrees of confidence in their attempts to control and care for their

family. Parents perceptions of their ability to handle specific behaviours of their child provides valuable information that can be explained with reference to he social learning theory. Causal factors effecting a family system are part of a reciprocal interaction of effects. The self-efficacy construct could be a useful model to explain how parents perceive their capabilities in managing their child.

CHAPTER TWO : METHODOLOGY

"...if the real world would just relax and cooperate " (Miller, 1986, p107).

A. AIMS AND RATIONALE

Self-efficacy theory proposes that given adequate skills and incentives, expectations of personal efficacy determine :

1. whether coping behaviour will be initiated,
2. whether it will be sustained in the face of difficulties, and
3. the degree of energy put into coping (Bandura, 1977).

Support for this construct has mainly come from work with phobic and smoking behaviours. There are no studies known to the researcher that have investigated parent self-efficacy during the management of their child.

Parental involvement in child management is crucial if the skills and behaviours learnt during an inpatient program are to be maintained after discharge. Maintenance of behavioural changes of the child also requires parent involvement in continuing management and persistence in the face of difficulties. If Bandura's postulate has utility, then increasing parental self-efficacy, with respect to the management of their child, is likely to be a consequence of involvement in the program and a predictor of progress at long-term follow-up.

There are a number of aims that have been formulated

for this study :

1. to develop a questionnaire that is sensitive to parent self-efficacy during child management. Measurement of management self-efficacy will enhance our understanding of parents progress during treatment. Their belief regarding their parenting effectiveness requires investigation.
2. to investigate the behavioural performance of the child during the treatment phases of a short-term intervention program;
3. to evaluate the usefulness of scores on the self-efficacy questionnaire and determine whether they are good predictors of response during and after treatment;
4. to compare the childs performance and parents self-efficacy scores.
5. to support the theory that management self-efficacy and action are mutually causative during parent management of children.

The rationale behind these aims is to discover the relationship between the outcome of management, that is, the child's behaviour, and parents perceptions of their self-efficacy. Participation in child management by the parents often changes in method as they are exposed to new and different types of discipline. This highlights the important function of the parents in the child's rehabilitation. Their perceptions of effectiveness in mastering specific management tasks will contribute significantly to the overall outcome of intervention.

On the basis of the literature reviewed, the following

hypotheses were generated :

1. self-efficacy ratings will improve over time for parents completing the treatment program;

2. if parents perceive there to be changes in their child's behaviour due to their management, then their self-efficacy evaluations change;

3. increases in self-efficacy evaluation will covary with improved behavioural performance by the child, as perceived by the parents;

4. decreases in self-efficacy will covary with a decline in behaviour performance by the child, as perceived by the parents;

5. evaluations of self-efficacy over the period of treatment will be good predictors of long-term self-efficacy ratings, and consequently, the behavioural performance of the child.

B. THE CONTEXT : THE CHILD AND FAMILY UNIT (WARD 24)

This research is carried out in a child and family inpatient psychiatric unit. The treatment program is designed to provide extensive assessment and intensive treatment of children with all types of behavioural, learning, emotional or psychiatric disorders. Family involvment is emphasised. There are a number of reasons why

this is so.

Individual and group psychotherapy is provided for children and parents. The child experiences five weeks of hospitalisation, and five weeks of outpatient follow-up. This unit provides a time-limited treatment program for about ten children, up to the age of 13 years. Children spend the first two weekends on the unit, but the third and fourth are spent at home. This allows the staff the opportunity to assess the child's progress and try out recommendation for the family.

It also provides the parents with the opportunity to practice their new guidelines and consequences in the home, familiarise themselves with experiencing their child in the home again. After the inpatient discharge the child is returned to the home on a full-time basis, with continued liaison with staff. Discharge is characterised by a ritualistic 'goodbye' party for the child after the intense experience of hospitalisation and therapy. Children get a chance to farewell staff and other children. A primary therapist visits the family to support and offer guidance following this transition, while the family often visit the ward for family therapy sessions, individual or couple counselling.

During the short follow-up stage (the outpatient phase of the 10 weeks - Table one), a family's attempts to change can be aided by the continuing help of the primary therapist. The short 'honeymoon' stage often experienced

after treatment may be terminated by a recurrance of some problems. This is a sensitive stage in the maintenance of change.

C. SUBJECT CHARACTERISTICS

Each family admitted to the program, over a 5 month period was approached. Admission to the program occurs for one, sometimes two families, per week. This period of admissions was interrupted by the holiday break. No new families were admitted for four weeks during this time. Eventually 18 families were interviewed, from November 1986 through to March 1987, and briefed on the research requirements. A six month follow-up was completed for each family that satisfactorily completed the research requirements. The final pieces of data were collected in September, 1987. Unfortunately, 13 families did not complete the research requirements.

Engaging cooperation involved a detailed exploration of the research tasks. Each parent completed the management self-efficacy questionnaire (MSE) in the presense of the researcher. Difficulties and misunderstandings were discussed and clarified before the beginning of the program. An informal interview provided information on how the parents were feeling about their difficult child and its management, their expectations of the ward program and what attempts they had made to receive help in the past. Familiarisation with the research instruments was the main emphasis of this initial interview.

The five families who eventually completed the requirements are referred to by alphabetical labels. This is done to insure anonymity and aid the following explanation of results and discussion. The father is abbreviated to the numeral letter (1), and the mother is a (2) for each family. Reference to the management self-efficacy questionnaire will distinguish between either question one (1) or question two (2). For example, the question two answers by the father from family (C) will be abbreviated as Fam C (1,2).

FAMILY A : Fam A is a two parent family with three children. It is a reconstituted family with the target child being from the fathers first marriage. The two younger children are of the current parents. The three children are aged 6 years, 4 years, and 6 months. The focus child was the oldest and was admitted for bedwetting and non-compliance. Both parents wanted assistance with management.

They had attempted to receive help before the Ward 24 program. However, they were dissatisfied because this only involved the child and eventually unsatisfactory long-term results occurred. The parents had not learnt any new ways to manage their difficult child. Beginning the Ward 24 program was an important step for this family because the parents were involved in the re-management of their child. The experience was described as "...quite a turn-a-around".

The father was employed in a semi-skilled occupation, often working long hours and at times travelling away from home for some nights. The mother was a full-time house-parent. During the time of admission to the Ward program they were in the process of buying their first home and shifting. Both parents described themselves as being "...quite ready for change".

FAMILY B : Fam B is a two parent family with three children aged 14 years, 13 years, and 8 years. The 13 year old boy was a recommended admission through the children's court. The problems impinging on the legal system were conduct disorder type behaviours, non-compliance and school refusal. Both parents were feeling desperate and unconfident in management. The mother especially was unhappy and reluctant to continue manageing this child.This put a lot of strain on the marriage. The father had the better relationship with the focus child.

This family was struggling to be together. They began the Ward 24 program with a very negative attitude. They criticised the program as being "artificial" and "unrealistic". They believed the program gave their child more attention than they would ever be able to offer him.

Both parents were employed. The father aws a full-time skilled tradesman working shift hours, while the mother was part-time employed in a semi-skilled occupation. She was involved in the majority of management. Inconsistency in management was a major issue for this family, especially in

the handling of the focus child.

FAMILY C : Fam C is a two parent family with their youngest child being the only sibling at home. This 13 year old boy was admitted for management difficulties related to his query schizophrenic/depressive disorder. Concern at time of admission focused on the child's continuing education in high school and his inability to socialise with other peers. His relationship with his parents was a very dependent-type one. The family had previously been introduced to the Ward 24 program during a 24 hour admission of their child for observation and psychiatric assessment. Their outcome expectations had been sobered during this experience. They realised before the ten week program began that their child's progress would be slow.

Professional help for this family is a big reassurance for these parents. They acknowledged the value of being supported and understood. "It is good to know help is there". The father was employed in a full-time semi-skilled occupation, while the mother worked part-time from home.

FAMILY D : Fam D is a two parent family with three children. The admitted child was an 11 year old and adopted. The younger siblings were 9 and 7 years. He was admitted for conduct disorder-type behaviours, and especially for stealing public property.

These parents had attempted different types of management techniques to control and help their

relationship with their child. However, they were feeling desperate and wanted professional help to change their child. They felt that they were manageing their other children well and that this child was the problem. Framing the management issues in terms of a family dynamic resulted in considerable resistence from these parents.

Both these parents worked in full-time professional careers.

FAMILY E : Fam E is a two parent family. The father was a sickness beneficiary and did not attempt the questionnaires. The mother was afull-time parent. There were three children in the family. The admitted child was 10 years old with siblings of 6 and 4 years. He was admitted for school refusal and aggressive behaviour.

The mother faced the responsibility of the Ward 24 program and re-management of her child on her own. This often created difficuties with inconsistent management. The father handled the children's discpline in his own way. He had been institionalised for a large proportion of his life and the management of his children was predominately carried out by the mother. She initially had little faith that the professionals could help her child and family. This was supported by her experience of her husband's rehabilitation.

D. INSTRUMENTATION

In this study a questionnaire was developed to measure parents self-efficacy with relation to the management of their child, admitted to an inpatient child and family psychiatric unit. Its format was based on previous questionnaires designed to monitor self-efficacy with respect to problem drinking behaviour during treatment (Gibb, 1984), and weight loss and relapse during treatment for obesity (Hall, 1984).

First a list of items was generated which described various specific situations likely to be encountered by the parent. These descriptions of child behaviours spanned a variety of tasks, and various levels of difficulty, so as to satisfy the criteria of magnitude and generality proposed by Bandura (1977). A wide range of behaviours was also important due to the heterogeneous group of subjects. The purpose of the questionnaire was to measure the parents belief in their own abilities to change and be effective in the management of their focus child, and be sensitive to their possible difficulties in coping with management issues.

Three behaviour checklists that had been used by Ward 24 staff to assess parents perceptions of their child's problems provided detail of the types of behaviours that were handled during the program (refer to Appendix two). The first draft of the questionnaire was 60 questions in length. It was mooted before two primary therapists, who had more than 4 years experience working with children and families in the Ward 24 program. Following this discussion,

a more precise formulation, of the specific management issues faced by most parents entering the program, was reached. The questionnaire was shortened to 40 questions by :

1. eliminating repetitions of management situations and finding the best example to match a number of similarly described behaviours, and
2. removing examples of management that seemed unlikely to be addressed by most parents.

Each of the 40 items were rated by subjects on each of the two 5-point Likert-type scales. On the first scale the subject was to rate how confident they would be in dealing with the behaviour described in each item, that is, giving a magnitude rating of self-efficacy. The second scale required the subject to assess how confident they would be in dealing with a situation that they had previously not coped well in, that is, giving a measure of persistence. The Likert scales ranged from 'always confident' to 'never confident' for question one (1), and 'extremely confident' to 'not confident' for question two (2). Further information was obtained on page three of the questionnaire, requiring detail of time involvement in the program by the parents and self-efficacy ratings of target behaviours not mentioned in the initial 40 questions (refer to Appendix one).

The Revised Behaviour Problem Checklist (RBPC) is a recent expansion of the Behaviour Problem Checklist (BPC) (Quay, 1977) which has been widely used in the United

States as a symptom rating scale. It has been used with parents, teachers, and other significant adults. The majority of items that make up the BPC were derived from a study by Peterson (1961). After collecting case records from a university child guidance clinic, he selected common symptom components. They were refined by factor analysis into a 55-item scale. Quay and Peterson (1983) began the revision of the BPC for two principal reasons. First, they wished to widen its diagnostic scope. Second, they wanted to increase the robustness of its component items.

Refinement of the experimental RBPC has only recently been completed. The RBPC consists of 89 items that are scored according to the perceived severity of the problem. Each score ranges from 0 to 2. Only 77 of the items are actually used to determine the individual scores for each band of behaviours (refer to Appendix two). The RBPC measures wide-band dimensions of child behaviour. Normative data and reliability testing, validity and cross-cultural generality have been validated in New Zealand (Aman & Werry et al, 1983; Aman & Werry, 1984).

The visual analogue scale (VAS) was designed to measure recordings of behavioural performance of the child on designated target behaviours (refer to Appendix three). These behaviours were often not specifically mentioned on the MSE or RBPC. These target behaviours were also entered on the third page of the MSE questionnaire. A self-efficacy rating was obtained for these behaviours. This provided a regular gauge of how the staff and parents were perceiving

the child's progress. This information was not readily available other than reading daily ward notes or sitting in on staff meetings.

E. PROCEDURE

An outline of the data points was presented to them which they used as a calendar. Table 1 is an example of the data requirements and when the data was collected during the program. A consent form was also signed by the researcher and the parents (refer to Appendix five). Initially all the families approached agreed to partake in the research requirements.

The self-efficacy questionnaire was administered at the initial admission of the family to the program. During the 10 week program a maximum of two MSE measures was required. They were completed at home and took between 20 and 40 minutes. The RBPC was administered at significant junctures in the program, namely admission, the end of inpatient treatment, end of short-term follow-up and at long-term follow-up. The visual analogue scale of target behaviours was completed each week by the parents and the primary therapist. Target behaviours were discussed by the therapist, parents and the researcher, to clarify what was to be evaluated (refer to Table 1).

TABLE ONE

WEEK	MON.	TUES.	WED.	THURS.	FRI.	SAT.	SUN.	
1	MSE RBPC			MSE	VAS(STAFF + PARENTS)			
2				MSE	VAS	INPATIENT		
3	MSE			MSE	VAS			WEEKEND HOME
4		MSE		MSE	VAS			WEEKEND HOME
5	MSE			MSE	VAS RBPC			DISCHARGE
6		MSE		MSE	VAS			
7	MSE			MSE	VAS			
8		MSE		MSE	VAS	OUTPATIENT		
9	MSE			MSE	VAS			
10		MSE		MSE	VAS RBPC			END OF 10 WEEKS

VAS -- VISUAL ANALOGUE SCALE

RBPC -- REVISED BEHAVIOUR PROBLEM CHECKLIST

MSE -- MANAGEMENT SELF-EFFICACY

CHAPTER THREE : RESULTS

The results are presented in three sections. The first section describes the total scores on the MSE. Comparison is made between the mother and father in each family, and also between parents from different families. The second section includes a more detailed examination of the juncture points in the program (week one and five, week ten and long-term follow-up). Each of the total MSE scores (for question one only) is collapsed into aggregate totals of each level of self-efficacy evaluation. Thirdly, the measurements of the child's performance on the visual analogue and the RBPC are evaluated and compared with the self-efficacy ratings.

If self-referent thought mediates the relationship between knowledge and action, then there will be a close covariance between perceived management performance and the perception of self-efficacy with respect to management.

SECTION ONE : The total scores for each family are presented in Tables 2 and 3. The time period is accounted for by the data point numbers (2 to 11). Data point 1 is a pre-visit score taken prior to admission, while points (12 to 21) correspond to weeks 6 to 10. The long-term follow-up scores (F/U) are given at the end.

TABLE 2 : PARENT MANAGEMENT SELF-EFFICACY

SUM (MSE) : QUESTION 1, FATHER(1) AND MOTHER(2)

FAMILY	FAM A		FAM B		FAM C		FAM D		FAM E	
PARENT	1	2	1	2	1	2	1	2	1	2
TIME										
1	151	144	---	---	140	130	114	101	---	---
2	162	157	94	79	144	143	---	---	---	124
3	155	160	110	73	151	139	118	113		132
4	165	147	112	84	160	144	103	108		---
5	151	162	110	76	166	145	---	---		166
6	134	163	---	---	174	146	123	98		173
7	142	165	---	63	---	150	124	102		156
8	153	165	---	---	172	147	125	102		---
9	154	160	96	73	175	147	126	97		197
10	157	160	105	72	170	147	116	84		186
11	137	156	98	86	170	147	108	86		---
RANGE =	31	18	18	23	31	11	23	29		62

INPATIENT

--- = MISSING VALUES

TABLE 2 : CONTINUED

FAMILY	FAM A		FAM B		FAM C		FAM D		FAM E	
TIME / PARENT	1	2	1	2	1	2	1	2	1	2
12	146	153	99	85	162	147	116	84	---	198
13	147	150	100	103	158	147	123	85	---	199
14	150	151	---	114	165	146	---	---	---	200
15	149	150	104	103	161	148	92	81		200
16	148	145	103	96	---	---	---	---		200
17	149	152	106	99	167	147	107	82		200
18	148	153	---	---	---	---	85	74		200
19	154	153	102	105		---	---	---		200
20	159	161	102	106	---	---	---	---		---
21	160	162	99	104	---	---	---	---		---
F/U	163	147	109	99	163	160	---	---		163
F/U	163	152	111	101	167	164	---	---		179
RANGE =	14	17	7	29	9	1	38	11		2

OUTPATIENT

--- = MISSING VALUES

TABLE 3 : PARENT MANAGEMENT SELF-EFFICACY

SMM (MSE) : QUESTION 2, FATHER(1) AND MOTHER(2)

FAMILY	FAM A		FAM B		FAM C		FAM D		FAM E	
PARENT	1	2	1	2	1	2	1	2	1	2
TIME										
1	136	143	---	---	134	120	109	105	---	---
2	149	157	96	97	147	132	---	---	---	140
3	146	149	108	40	152	131	87	112	---	133
4	150	142	108	74	155	136	81	105	---	---
5	141	167	110	73	160	139	---	---	---	166
6	125	165	---	---	169	143	93	98		173
7	124	168	---	82	---	141	86	97		156
8	124	159	---	---	176	143	89	98		---
9	136	157	96	86	166	143	75	90		197
10	142	159	107	101	164	149	72	87		106
11	119	155	102	108	160	140	62	84		---

INPATIENT

--- = MISSING VALUES

TABLE 3 : CONTINUED :

TIME	FAM A		FAM B		FAM C		FAM D		FAM E	
	1	2	1	2	1	2	1	2	1	2
12	129	157	106	117	159	142	60	84	---	199
13	137	153	107	125	158	142	58	86	---	200
14	130	149	---	117	164	142	---	---		200
15	136	147	111	121	174	141	49	82		200
16	139	146	107	114	---	---	---	---		200
17	147	151	107	115	180	142	56	84		200
18	150	154	---	---	---	---	51	74		200
19	155	155	111	94	---	---	---	---		200
20	163	164	108	110	---	---	---	---		---
21	164	164	103	90	---	---	---	---		---
F/U	150	150	109	96	162	156	---	---		159
F/U	150	151	113	119	172	155	---	---		177

OUTPATIENT

--- = MISSING VALUES

The ananlysis of variance for repeated measures and mean scores for each parent were calculated using a BMDP2V statistical package (Dixon, 1981). Individual mean scores provide information on the comparative scores between parents and families. The scores are rounded up to the nearest whole number for ease of reference. Total MSE scores were defined as the dependent variable. The independent variables were parent (1 or 2) for each family, and question (1 or 2) for each parent.

The ANOVA summary tables (refer to Appendix four) indicate that the parents in Fam A, B, and C scored significantly different results to the other parent in the family at the ($p<.01$) level. Their individual scores were distributed significantly from the other parent. The parents from Fam D did not produce significantly different scores to each other. Two suggestions explain this initial finding. Firstly, each parent experiences differenl amounts of management responsibility and they tend to select and manage different sorts of behaviour. The mother and father experience different levels of self-efficacy to each other. Secondly, parents answered the questionnaire at different times during the day. Therefore, their scores were not completed under the same conditions.

Variance in the total scores was also effected by the differences in answers between question one and question two. Fam A and D produced significant results at the ($p<.01$) and Fam B at ($p.<05$), that is, their individual

answers on question one and question two of the MSE were distributed significantly. The mean scores for questions one and two were significantly different. Two tentative conclusions are made to explain these initial findings. Firstly, question one and question two were answered separately and independently from each other. Secondly, the answers to question two were possibly formulated after the question one responses. They reflect a measure of strength of self-efficacy which during failure in management (re. questionnaire) they would feel less affective. This would be a function of their magnitude score on question one. Answers to questions one and two map each other. This is verified by looking at the graphs of total MSE scores (Figures 1(A,B,C,D,E) and 2(A,B,C,D,E)) and comparing highest and lowest scores for each family on both questions. This result adds weight to the second conclusion.

The significant interaction between parent and question independent variables for Fam A and D ($p<.01$) suggests that these parents may have independently rated each question and avoided influential discussions regarding their answers.

Graphs of the total MSE scores (for question one and two), taken sequentially during the admission, discharge and follow-up phases of treatment, indicate some interesting trends.

1. All the families levels of self-efficacy increase across

the 23 data points, except for Fam D (Figures 1(A,B,C,D,E)). Figures 2(A,B,C,D,E) represents total scores for question two. This measure of persistence shows a similar change in scores over time, though the troughs on the graphs tend to be assentuated. This may be because of the above reasons, or because during a period of low self-efficacy, a parent will experience a considerably lessened belief in persistence. A very good example of this is given in Firure 1D and 2D for the fathers comparative scores. Persistence can be high, however, when a childs behavior is difficult, especially in the initial stages of the program. An example of this is demonstrated by the mother of Fam A (refer to Figure 1A and 2A).

2. The range of scores presented in Tables 2 and 3 supports the conclusion that parents experience distinctly different levels of confidence in management.

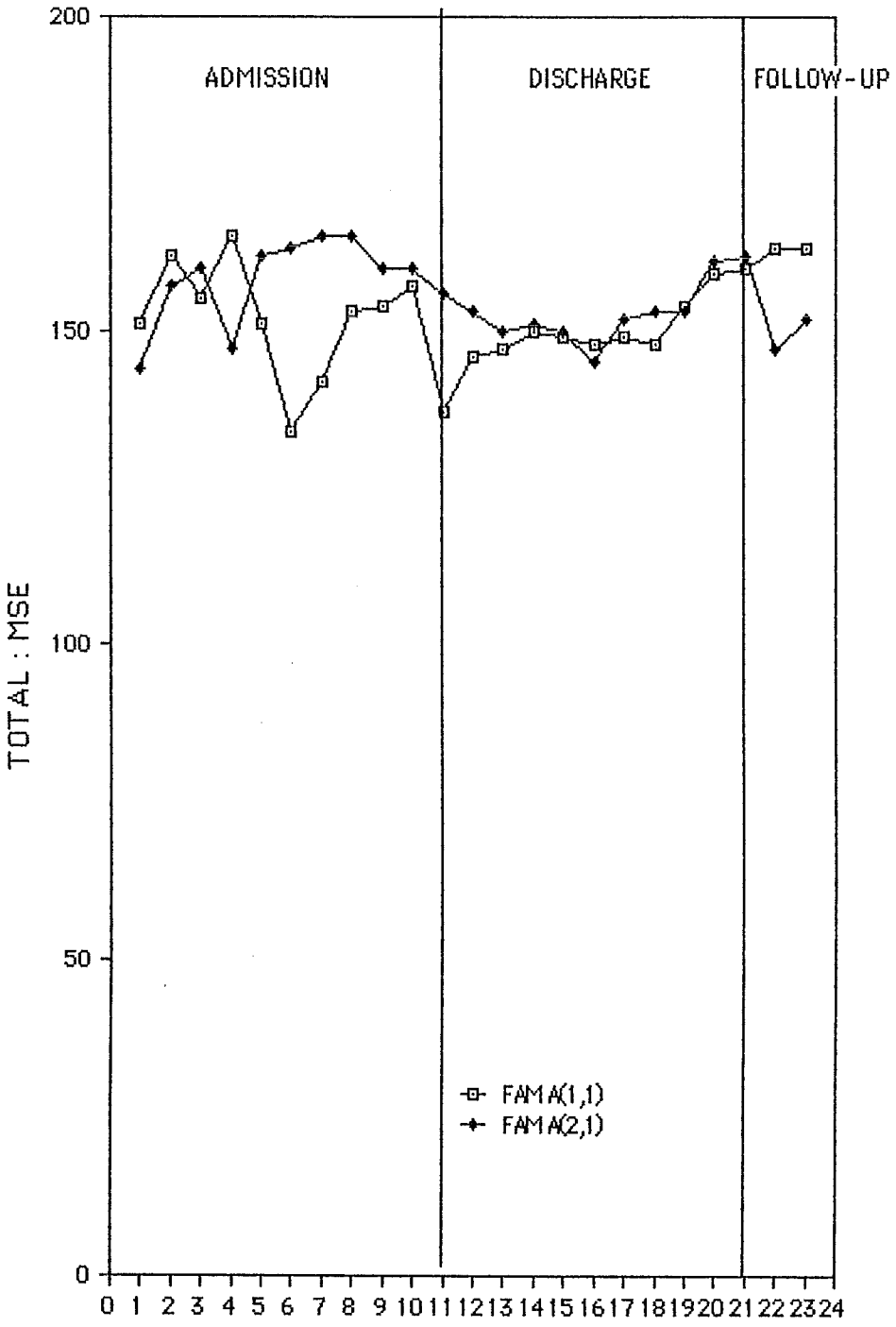
Data presented in Table 4 indicate that all families, that were able to complete the questionnaire at long-term follow-up, were scoring higher in confidence ratings. Pre-visit scores indicate that, once help was obtained, the confidence in management increased. Furthermore, the highest scores for each parent during the 10 week treatment phase correspond closely with the scores obtained at long-term follow-up. They are significantly higher than the lowest scores , which mostly occurred in the first five weeks for all families except Fam D. The ratings of self-efficacy for Fam D parents continued to decline throughout the program.

Interestingly, at long-term follow-up, Fam D had relinguished the responsibility of management of their child. He was being cared for by a foster family one month after the end of the 10 week program. As parents, they felt grief and disappointment at "giving-up", but they considered the whole family was being effected to adversely by the target child's behaviour.

TITLE : TOTAL SCORES FOR QUESTION ONE ON THE MSE.

FATHER = 1 AND MOTHER = 2.

FIGURE 1A(MSE)

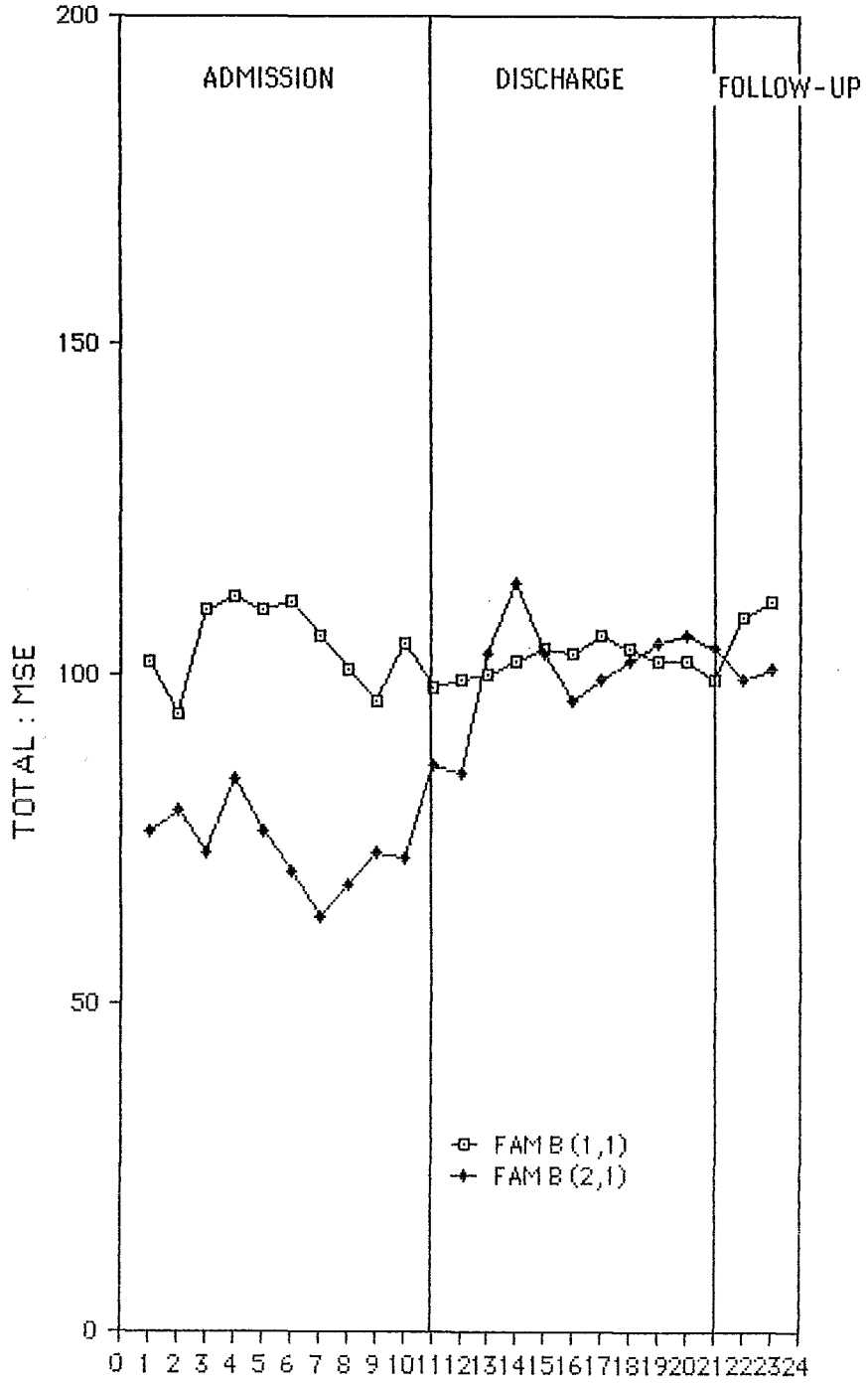


TIME : DATA POINTS

TITLE : TOTAL SCORES FOR QUESTION ONE ON THE MSE.

FATHER = 1 AND MOTHER = 2.

FIGURE 1B(MSE)

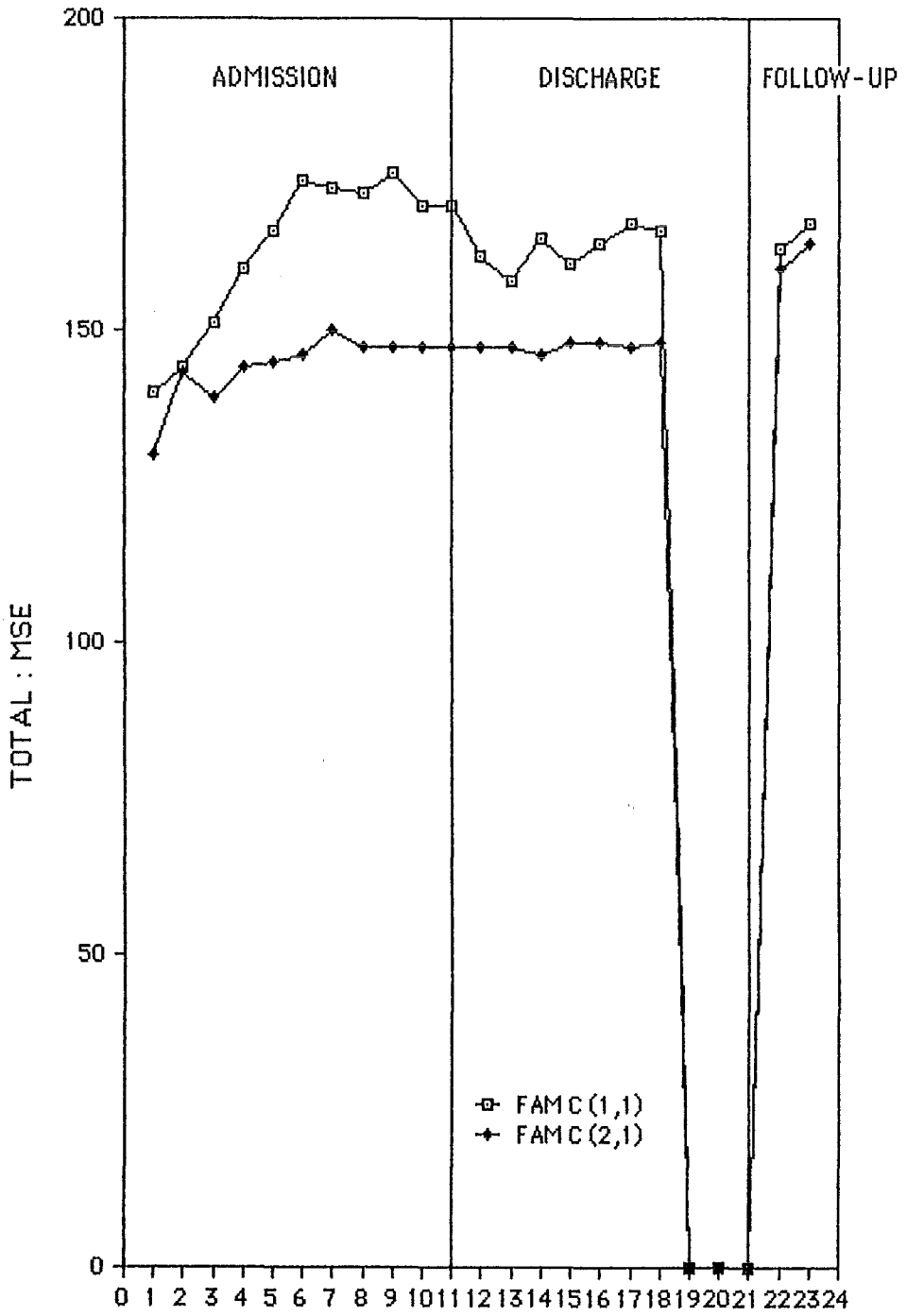


TIME : DATA POINTS

TITLE : TOTAL SCORES FOR QUESTION ONE ON THE MSE.

FATHER = 1 AND MOTHER = 2.

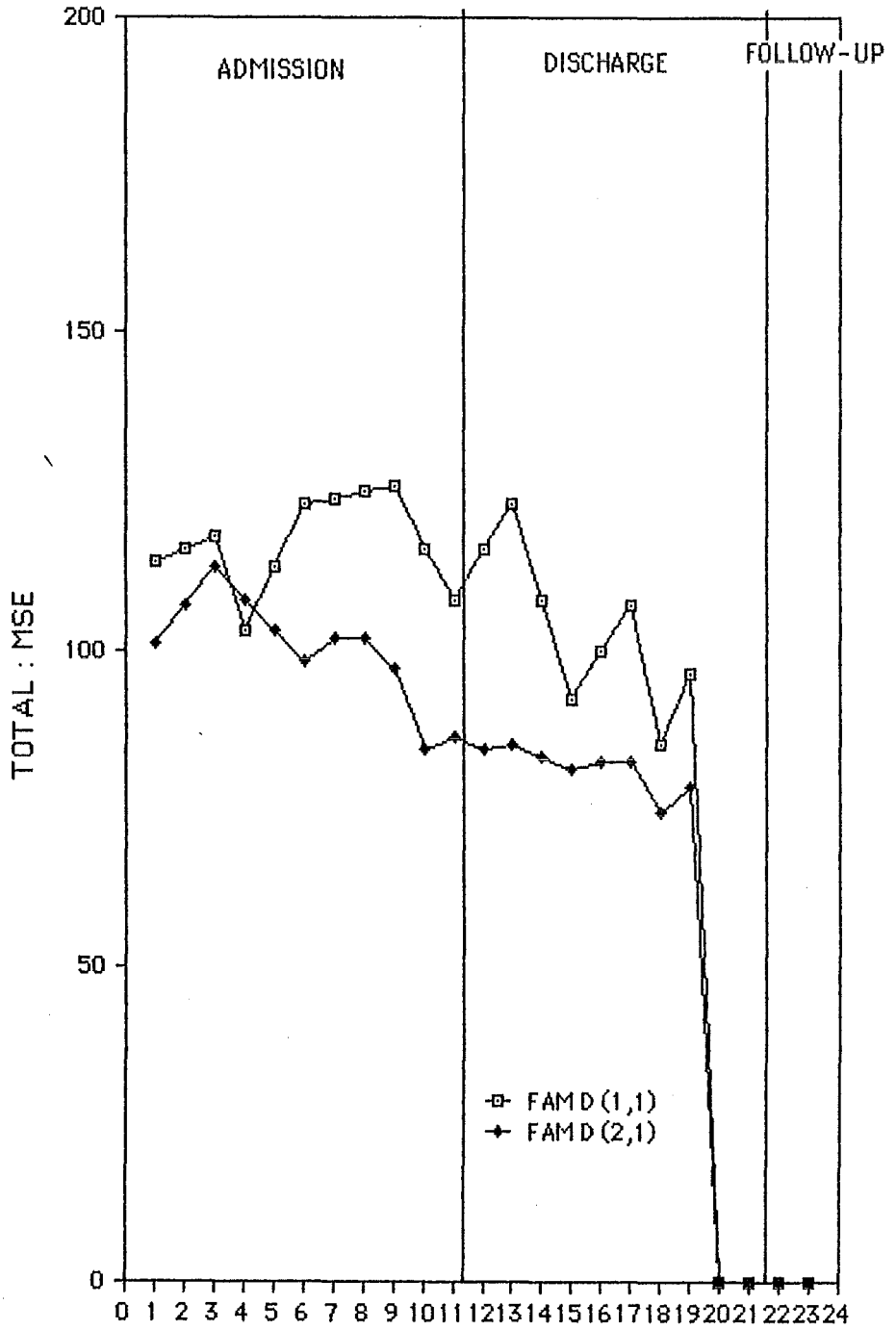
FIGURE 1C(MSE)



TITLE : TOTAL SCORES FOR QUESTION ONE ON THE MSE.

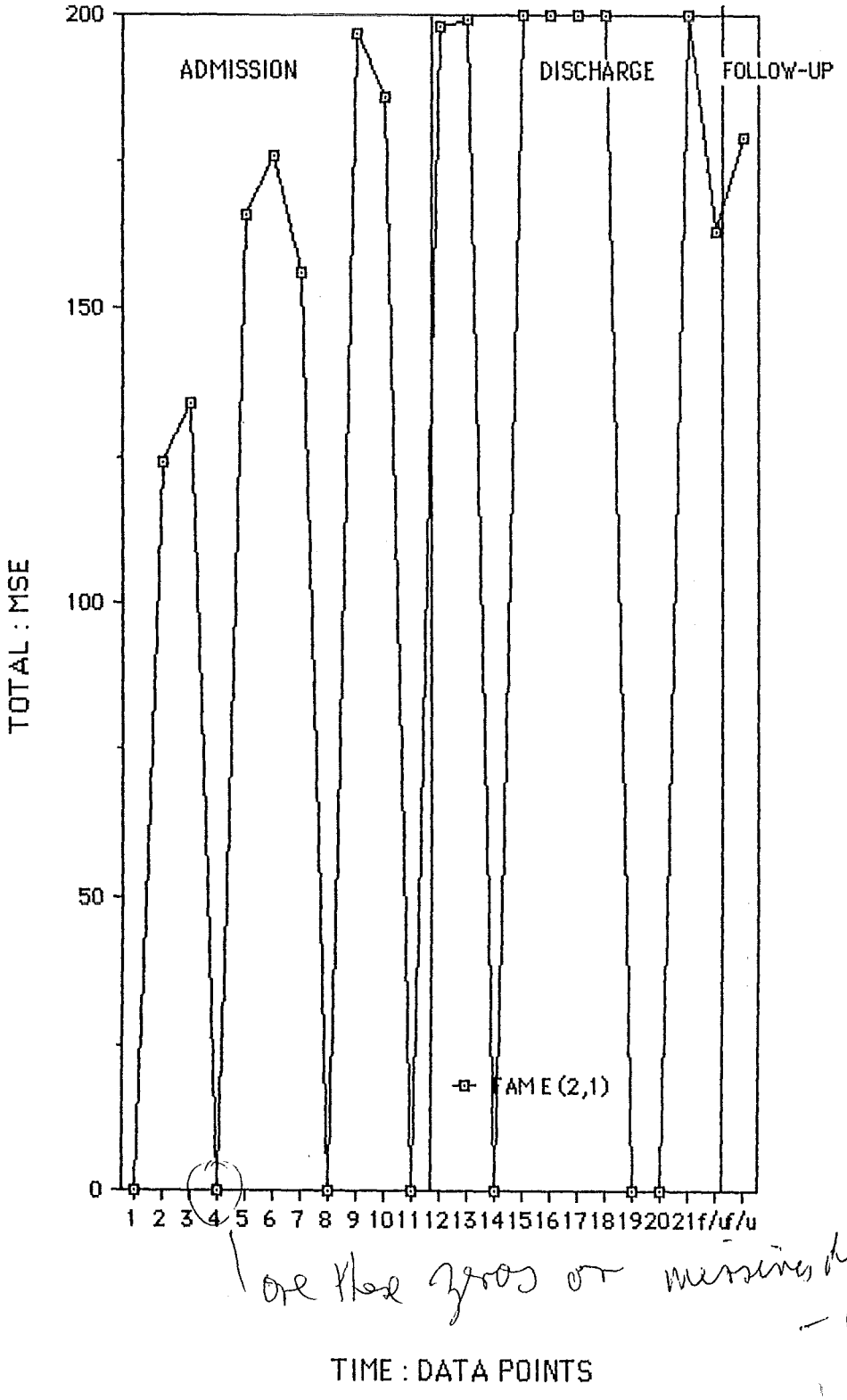
FATHER = 1 AND MOTHER = 2.

FIGURE 1D(MSE)



TITLE : TOTAL SCORES FOR QUESTION ONE ON THE MSE.
FATHER = 1 AND MOTHER = 2.

FIGURE 1E(MSE)

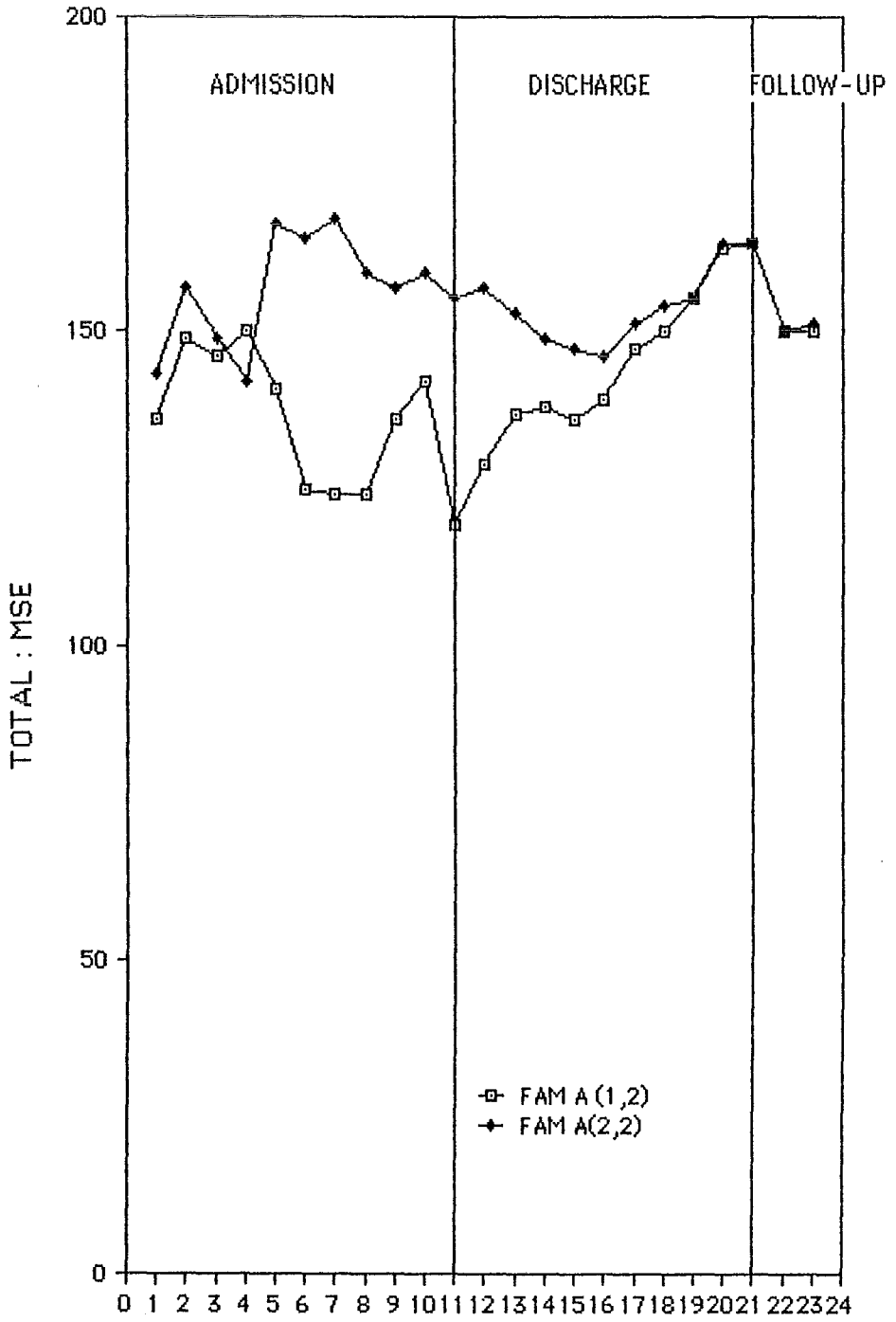


one has zeros or missing data - probably.

TITLE : TOTAL SCORES FOR QUESTION TWO ON THE MSE.

FATHER = 1 AND MOTHER = 2.

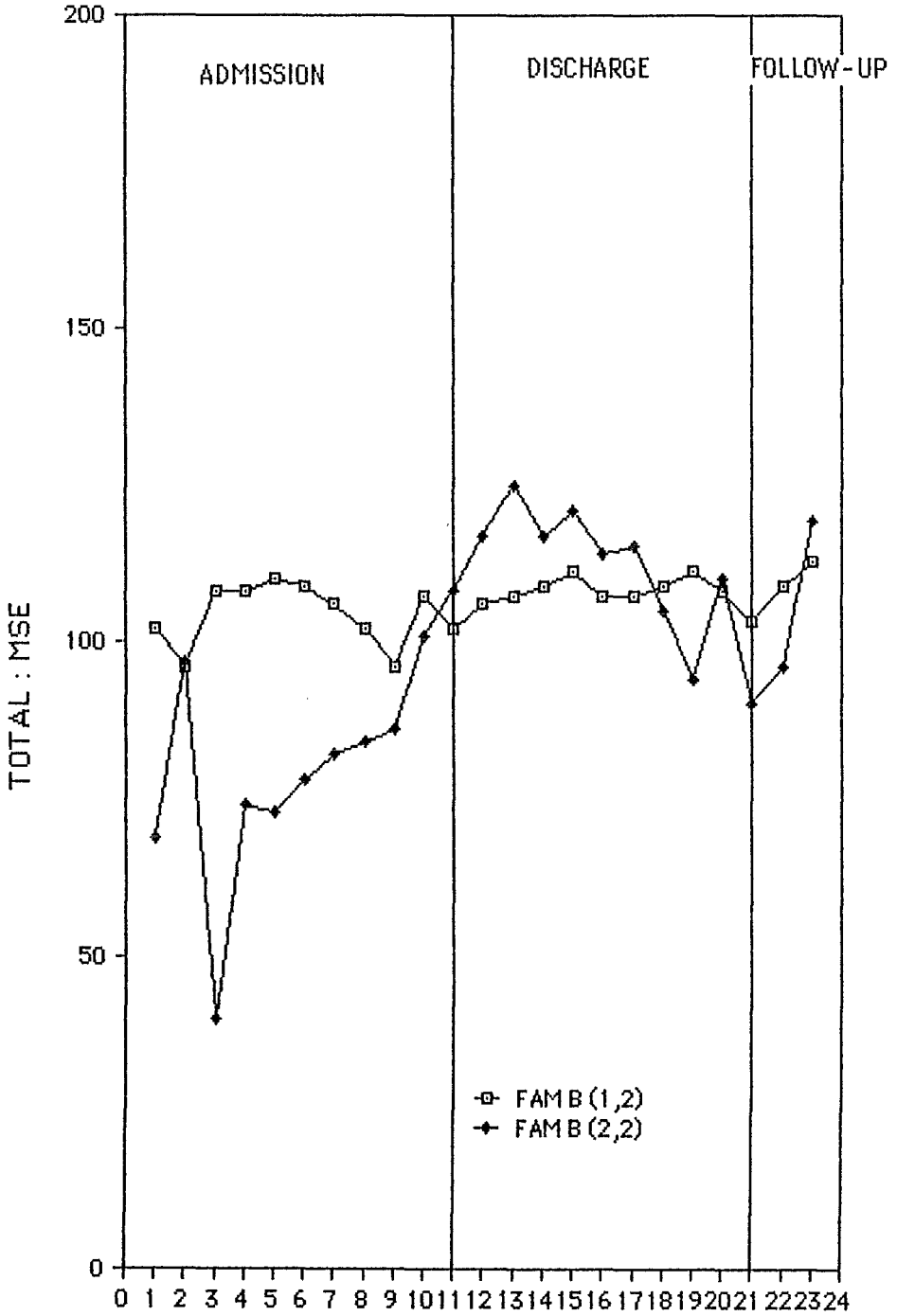
FIGURE 2A(MSE)



TITLE : TOTAL SCORES FOR QUESTION TWO ON THE MSE.

FATHER = 1 AND MOTHER = 2.

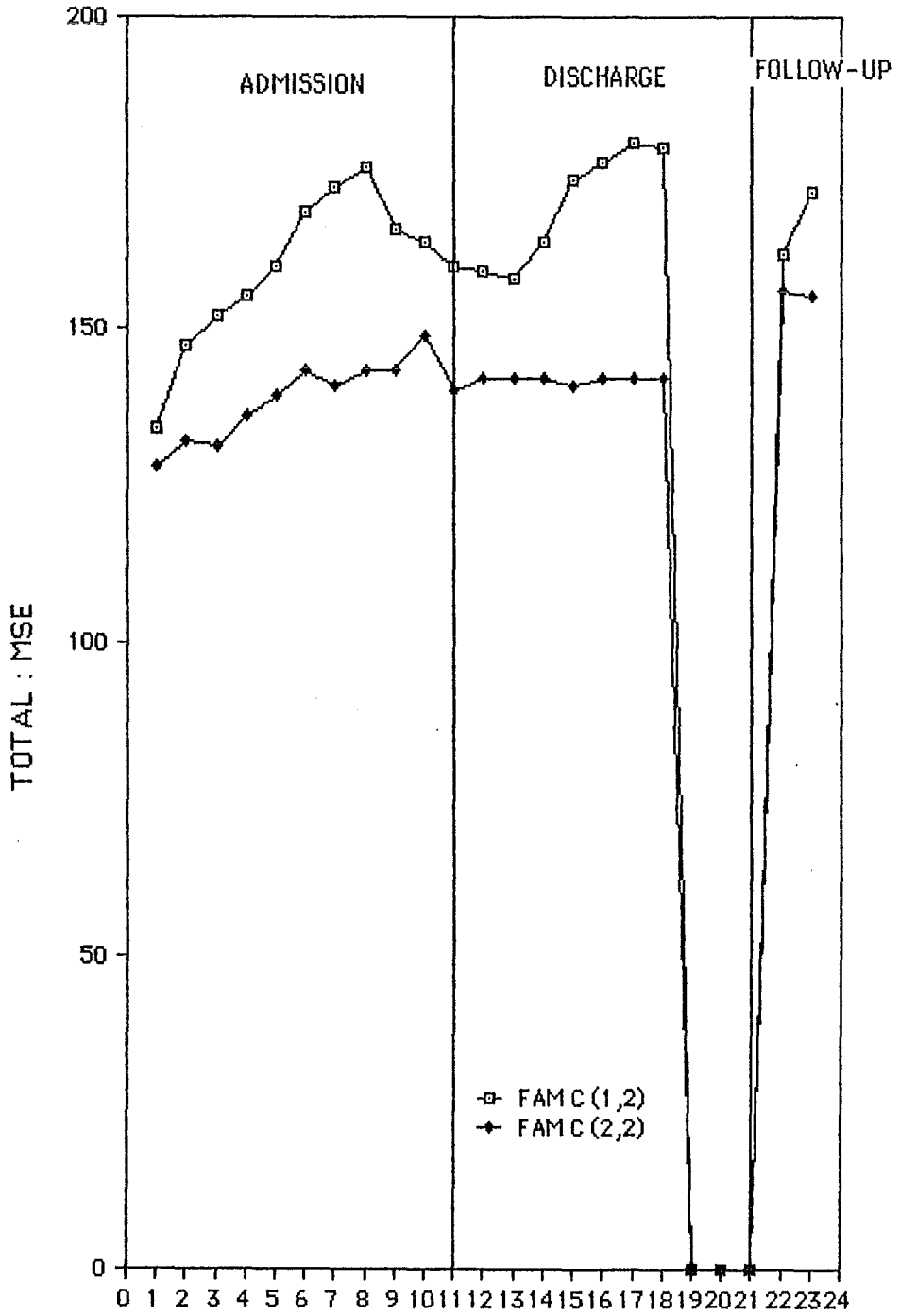
FIGURE 2B(MSE)



TITLE : TOTAL SCORES FOR QUESTION TWO ON THE MSE.

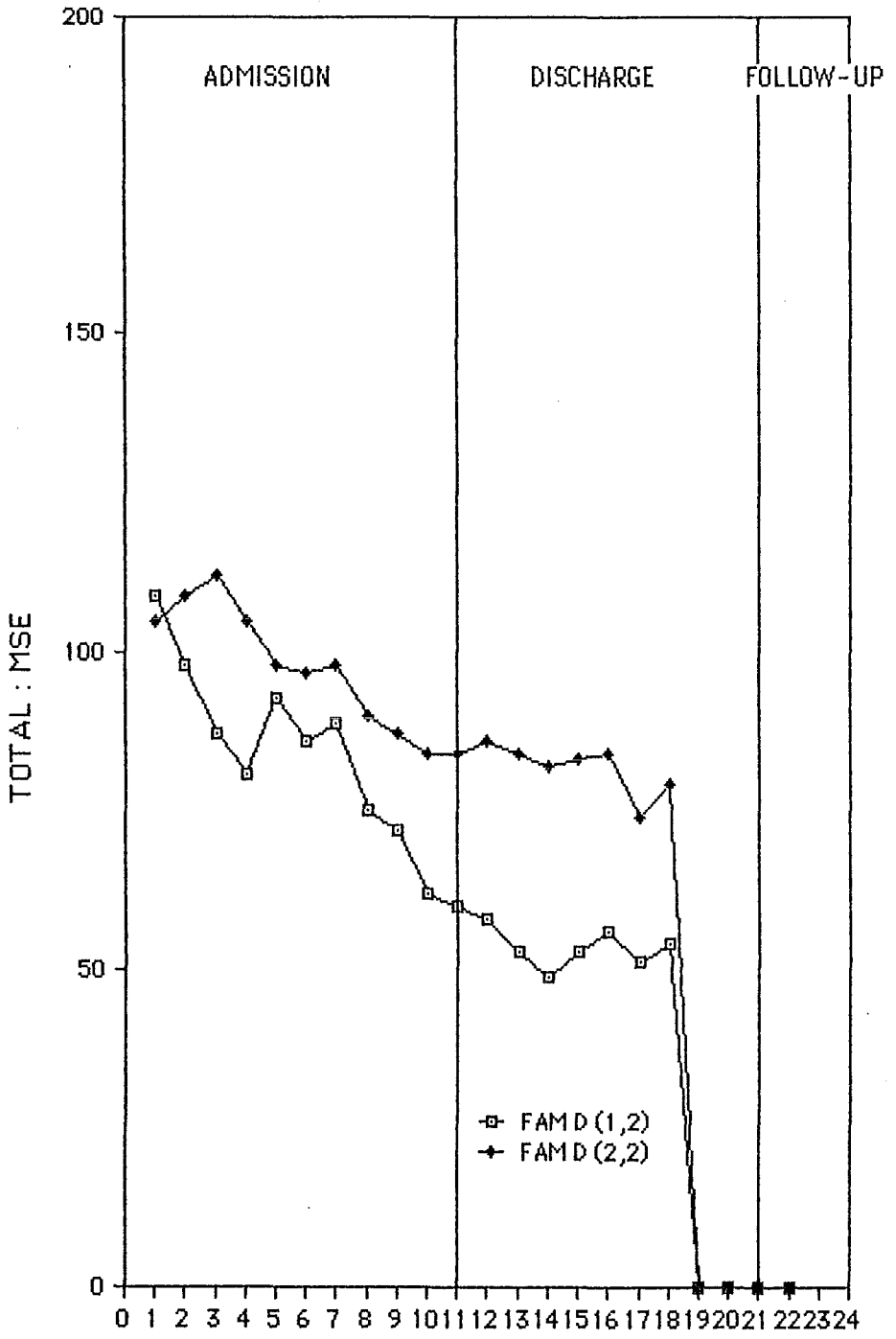
FATHER = 1 AND MOTHER = 2.

FIGURE 2C(MSE)



TITLE : TOTAL SCORES FOR QUESTION TWO ON THE MSE.
FATHER = 1 AND MOTHER = 2.

FIGURE 2D(MSE)



TITLE : TOTAL SCORES FOR QUESTION TWO ON THE MSE.

FATHER = 1 AND MOTHER = 2.

FIGURE 2E(MSE)

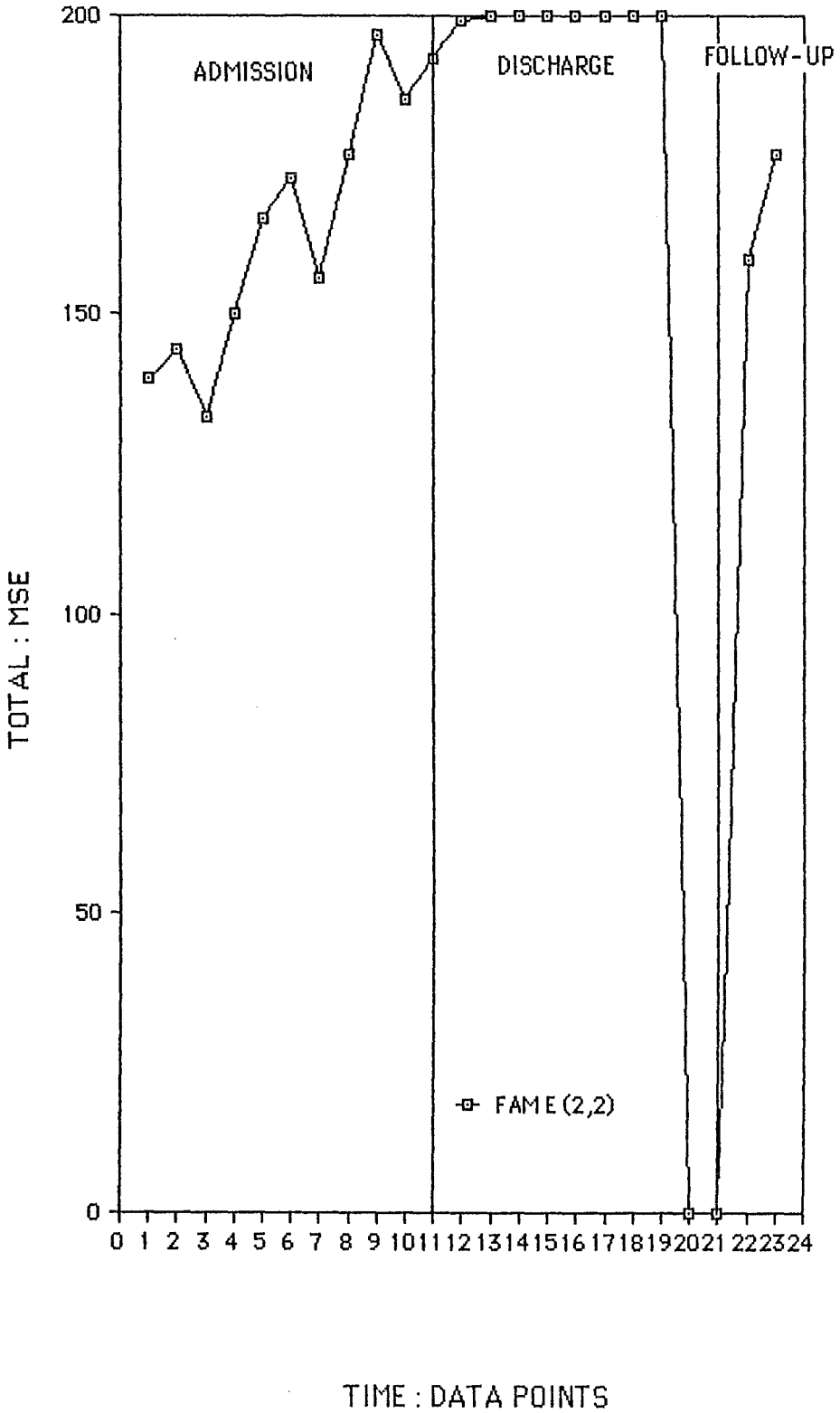


TABLE 4 : PARENT MANAGEMENT SELF-EFFICACY MEANS FOR QUESTION ONE.

FAMILY	A		B		C		D		E
PARENT	1	2	1	2	1	2	1	2	2
PRE-VISIT	151	144	---	---	140	130	114	101	---
1-5 WEEKS	152	158	104	75	163	147	117	100	162
6-10 WEEKS	151	153	102	102	165	162	104	02	199
6 MONTHS	163	150	110	100	165	162	---	---	171
TOTAL MEAN (10 WEEKS)	151	156	103	07	163	145	112	93	181

Scanner’s Note: Pages 89 and 90 are absent from the original thesis

SECTION TWO : Analysis of the various levels of confidence responses for question one also provides information on how many situations parents feel a given level of self-efficacy. For instance, self-efficacy total scores on question one for Fam B(2,1) during the inpatient admission phase included a maximum of 25 'e' responses on one questionnaire and a minimum of 11 'e' responses on another. During the short-term discharge phase, the maximum number of 'e' responses was 13, and the minimum number was 2. This demonstrates how this mother's lowest level of self-efficacy rating changed dramatically. She started feeling more confident in management and her belief in 'never' being effective in situations of management lessened. At long-term follow-up her scores were 8 and 9 for 'e' responses. Level 'e' responses usually reflected a very low mood for the parent. A low mood often indicated that the parent was feeling disheartened with the child's progress. Anecdotal evidence supported this conclusion for this mother.

The following graphs (Figures 3(A,B,C,D,E)) illustrate the total number of responses for each level of self-efficacy rating on question one. That is, answers from 'a' to 'e', with 'e' being the lowest. Total scores are selected from, (1) the beginning of admission (week one); (2) the end of admission (week two); (3) the end of short-term follow-up (week ten); and (4) two measures from long-term follow-up (six months). More detailed scores of the number of responses for each level on every

questionnaire answered are given in Tables 5 to 9.

All the families highest level scores at discharge (level 'a' responses) corresponded with the long-term follow-up results. The lowest level of self-efficacy rating ('e' responses) either diminished or remained relatively constant for every family except Fam D. At week one the father totalled 12 'e' responses and 7 at 5 weeks. At the last data point of the treatment phase their 'e' responses had risen to 17. This was also their highest level score for all of their aggregate totals. The mothers 'e' responses were 11 and 20 for weeks 1 and 5 respectively. At the 10 week point they had risen to 24. Her belief in 'never' being confident in management situations had generalised.

Figures 3A(2,1) and (1,1) provide the results for family A mother and father respectively. The highest scores for responses were the 'b' answers. These increased from 16 at week 1 and 5 to 28 at week 10 and 6 months. The fathers 'b' scores were also the highest tallied, increasing from 18 at week 1 to 23 at week 5. At week 10 it was 22 and at 6 months follow-up it was 25. Both parents showed an increase in their 'very' confident answers. Their comments during follw-up at the 10 week point and 6 month point confirmed this result. They were not feeling as desperate as they had done before the program and at times during the inpatient phase when their child was difficult to handle. Both the parents from this family fely they had learnt some helpful skills in management and these were applicable to most

management situations.

The highest scores for the father in family B were for 'c' responses on question one. His 'moderately' confident responses diminished from 26 at week one to 18 at week 5. However, at week 10 they had risen to 21 and at 6 m0nth follow-up they were 28 and 30. Interestingly, both the parents talked of the inpatient period as being unhelpful and resisted some of the professional help in the initial stages. The fathers diminished 'c' responses support this, but the mother did improve, by lessening her 'e' responses. Her 'c' and 'd' responses increased accordingly.

The fathers responses for family C remained relatively stable throughout the period. Each of the juncture points selected provided scores that were very similar on all levels of self-efficacy rating. The mothers scores did show some changes. Her 'b' responses increased during the 10 week program from 25 to 29. However, at 6 month follow-up her 'b' responses had diminished substanyially to 17 and 16. This meant an increase in 'a' responses. She was feeling even more efficacious in management.

Results for the mother in family E (Figure 3E(2,1)) illustrate that at the 10 week period she was still experiencing a 'honeymoon' effect of the treatment program. Her belief in being effective in management had sobered at 6 month follow-up and had returned to a higher level than the week 1 measure. Importantly, she did not report any 'd' or 'e' reponses. She was feeling 'moderately' confident or

better.

Comparing each of these families provides some useful information to draw some tentative conclusions. The two main points worth noting are :

1. an increase in higher level 'a' scores at 'discharge', compared with the 'admission' phase scores, seems a good indicator of long-term maintenance of management self-efficacy;

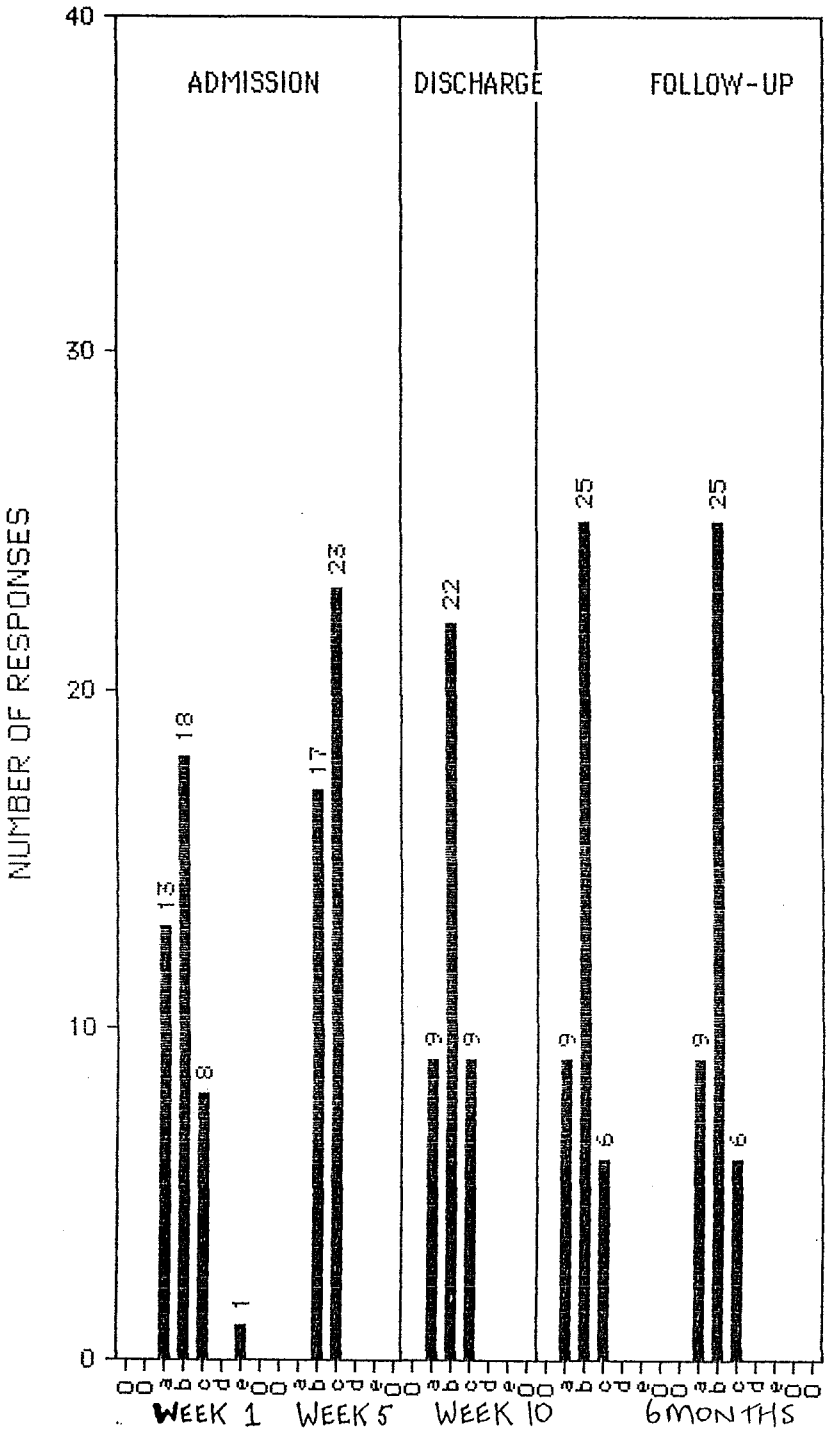
2. an increase in lower level scores at 'discharge', compared with the 'admission' phase, may indicate poor long-term outcome of treatment.

TITLE : LEVELS OF SELF-EFFICACY AT SPECIFIC POINTS IN THE PROGRAM.

FATHER = 1 AND MOTHER = 2

QUESTION = 1 OR 2.

FIGURE 3A(1,1)

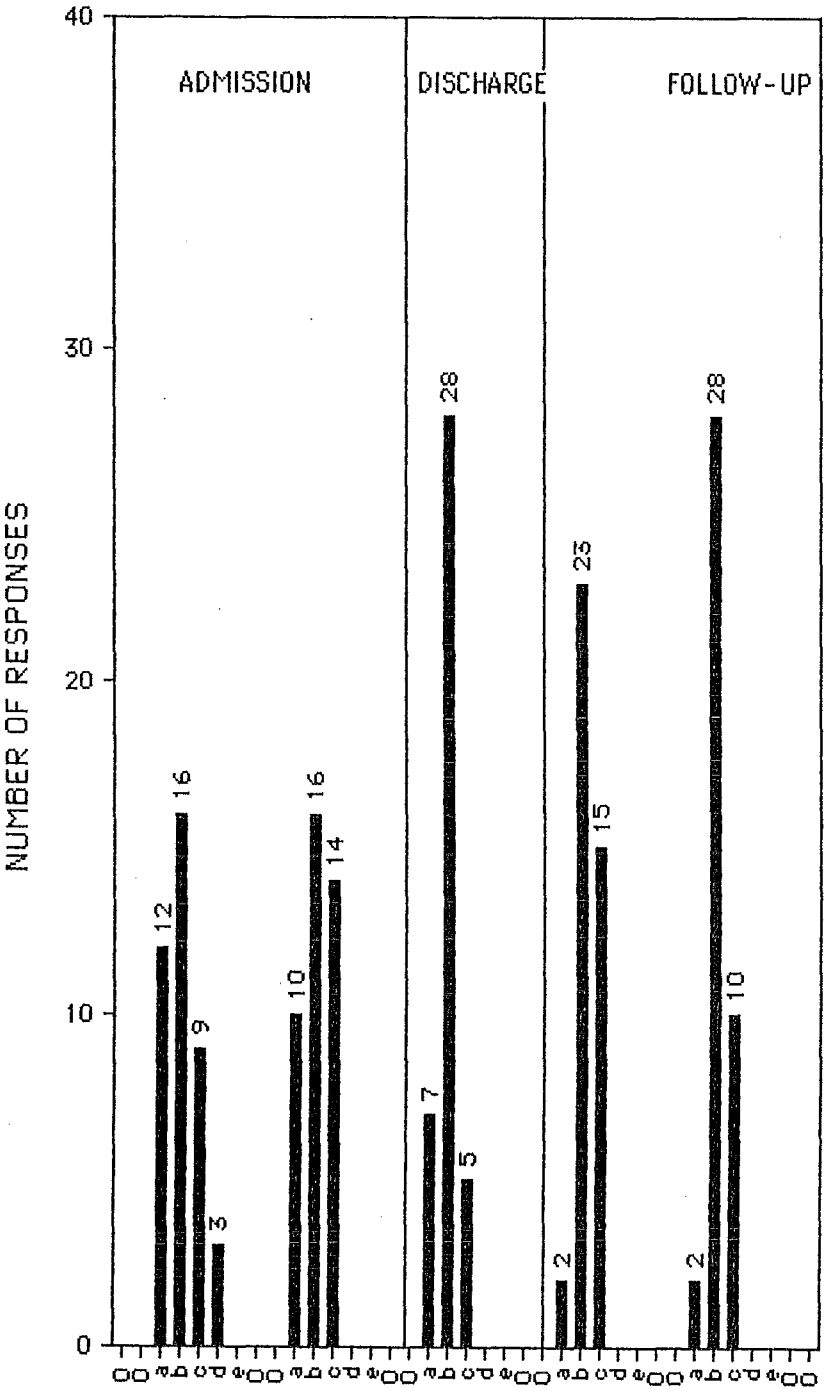


TITLE : LEVELS OF SELF-EFFICACY AT SPECIFIC POINTS IN THE PROGRAM.

FATHER = 1 AND MOTHER = 2

QUESTION = 1 OR 2.

FIGURE 3A(2,1)

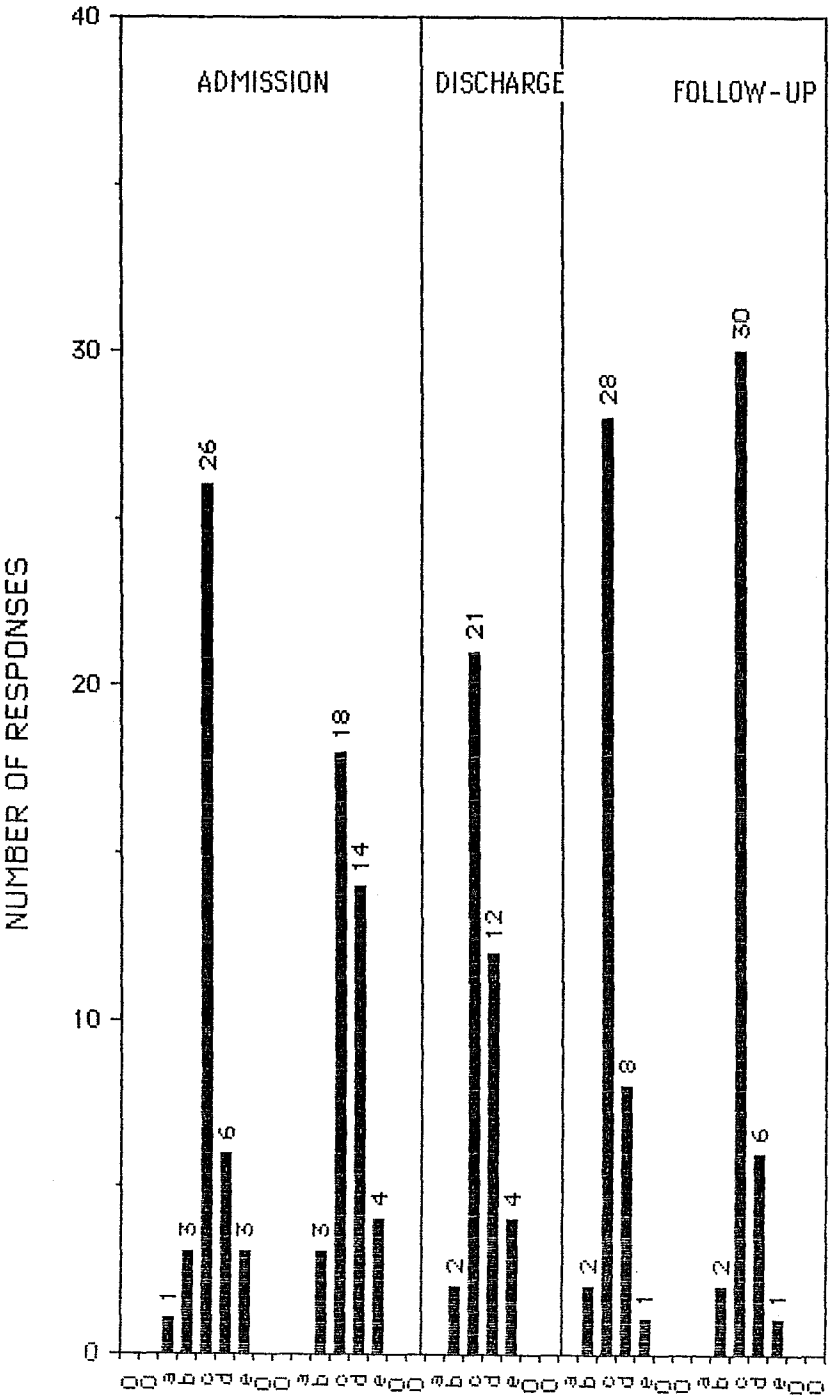


TITLE : LEVELS OF SELF-EFFICACY AT SPECIFIC POINTS IN THE PROGRAM.

FATHER = 1 AND MOTHER = 2

QUESTION = 1 OR 2.

FIGURE 3B(1,1)

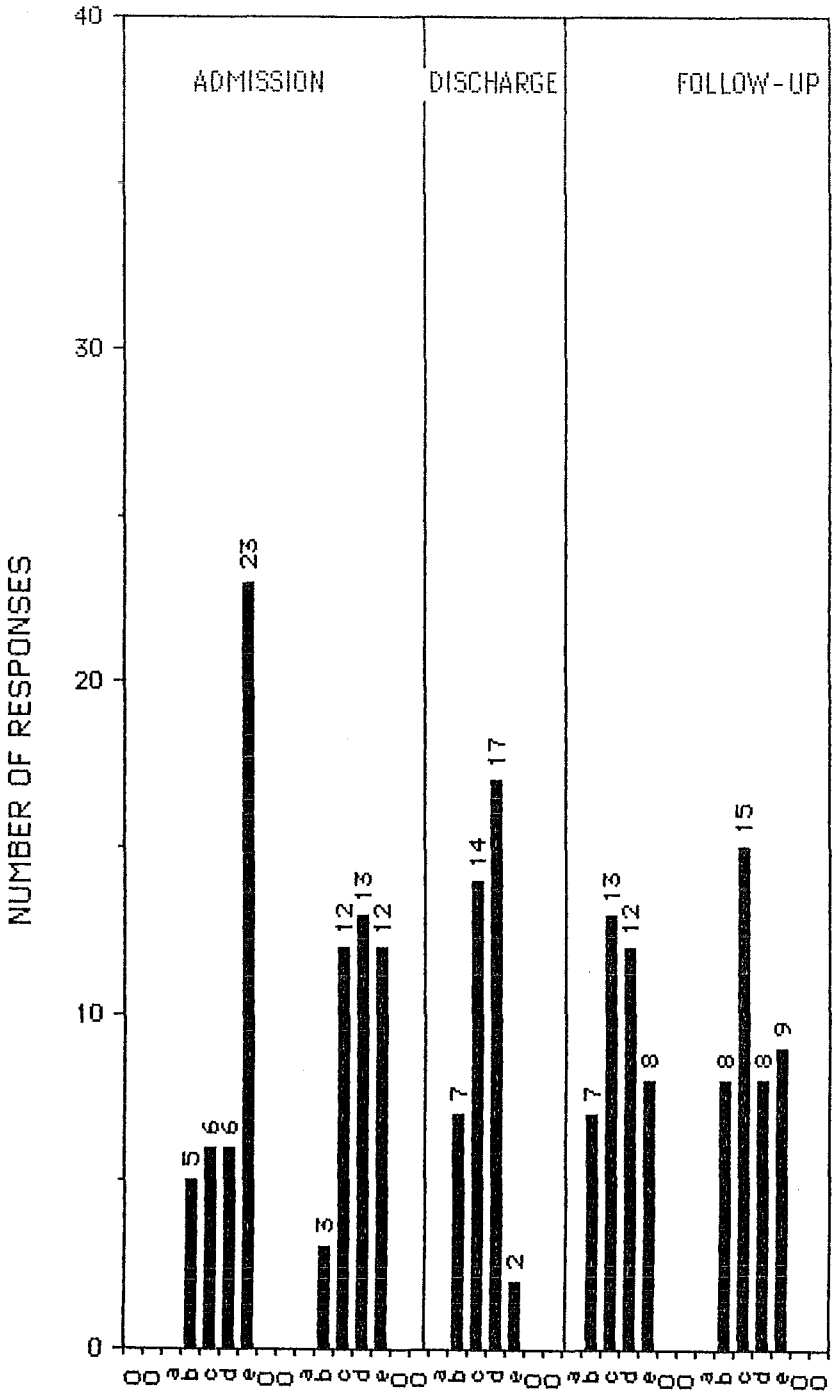


TITLE : LEVELS OF SELF-EFFICACY AT SPECIFIC POINTS IN THE PROGRAM.

FATHER = 1 AND MOTHER = 2

QUESTION = 1 OR 2.

FIGURE 3B(2,1)

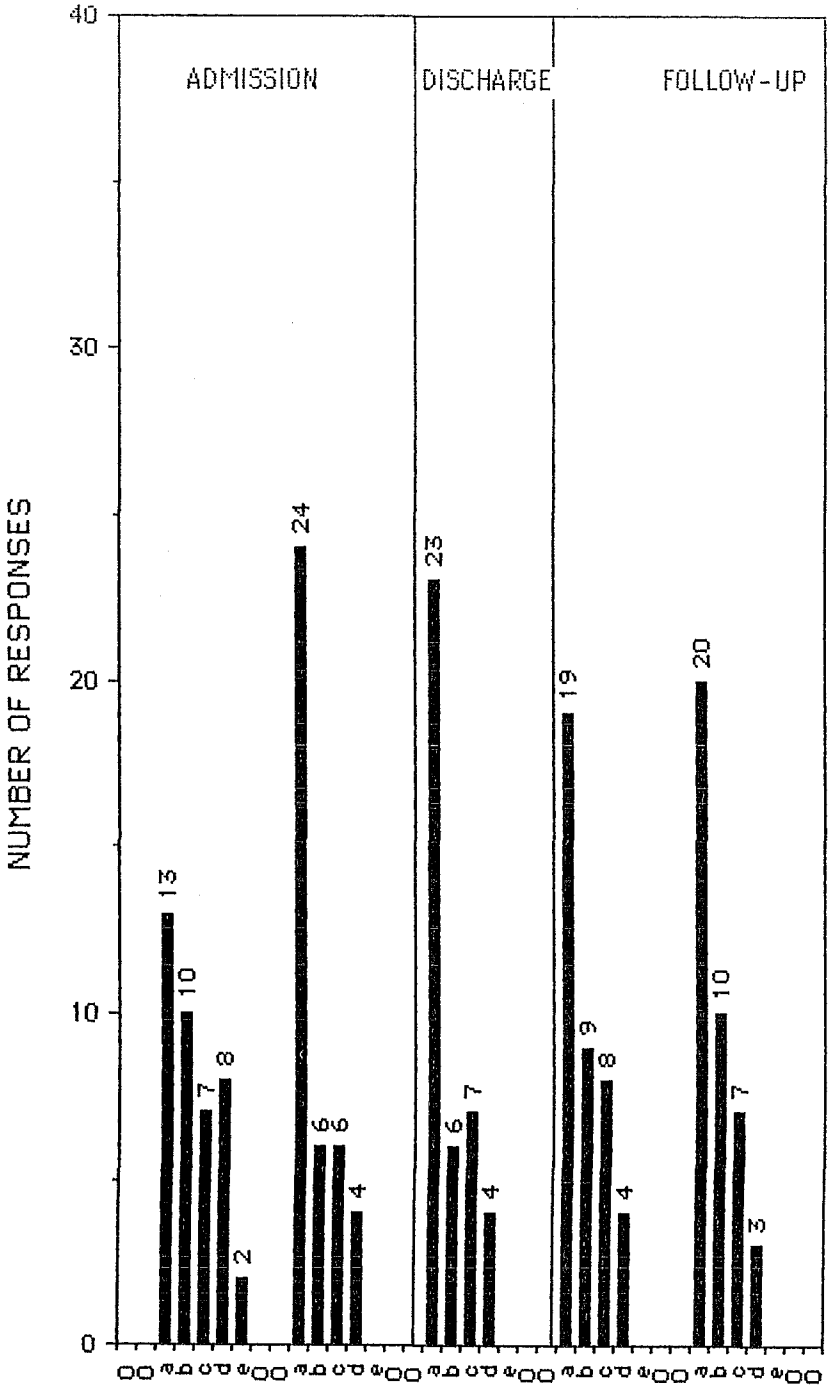


TITLE : LEVELS OF SELF-EFFICACY AT SPECIFIC POINTS IN THE PROGRAM.

FATHER = 1 AND MOTHER = 2

QUESTION = 1 OR 2.

FIGURE 3C(1,1)

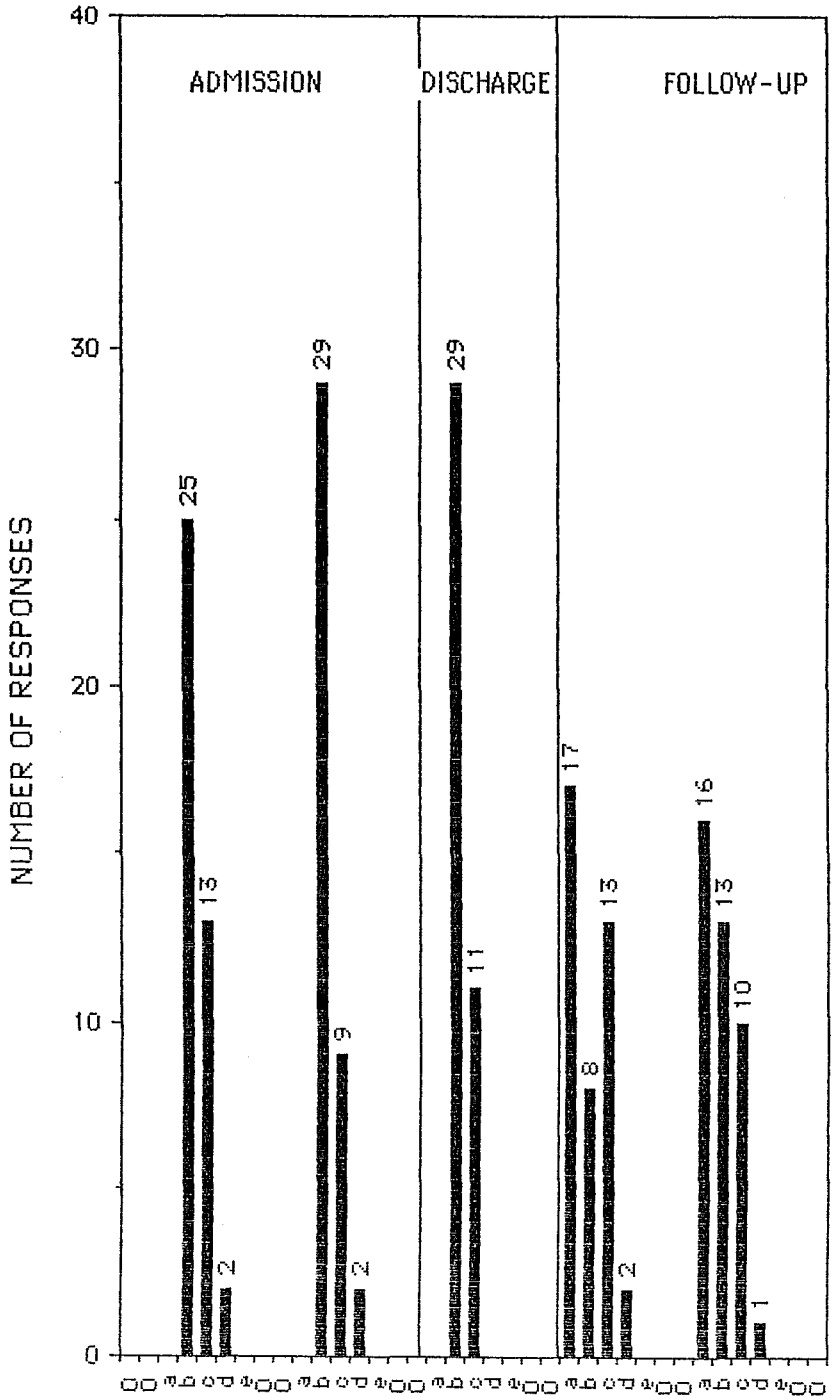


TITLE : LEVELS OF SELF-EFFICACY AT SPECIFIC POINTS IN THE PROGRAM.

FATHER = 1 AND MOTHER = 2

QUESTION = 1 OR 2.

FIGURE 3C(2,1)

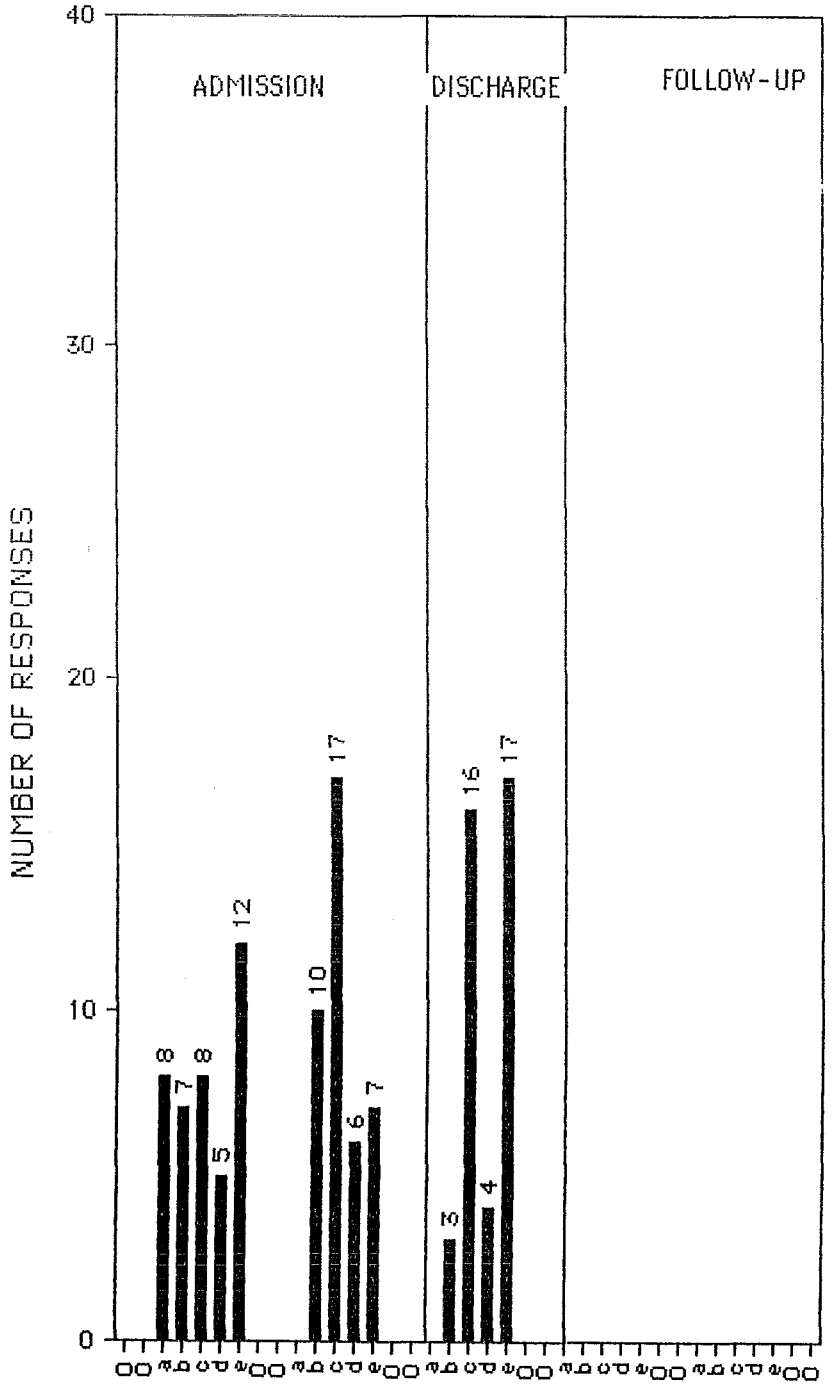


TITLE : LEVELS OF SELF-EFFICACY AT SPECIFIC POINTS IN THE PROGRAM.

FATHER = 1 AND MOTHER = 2

QUESTION = 1 OR 2.

FIGURE 3D(1,1)

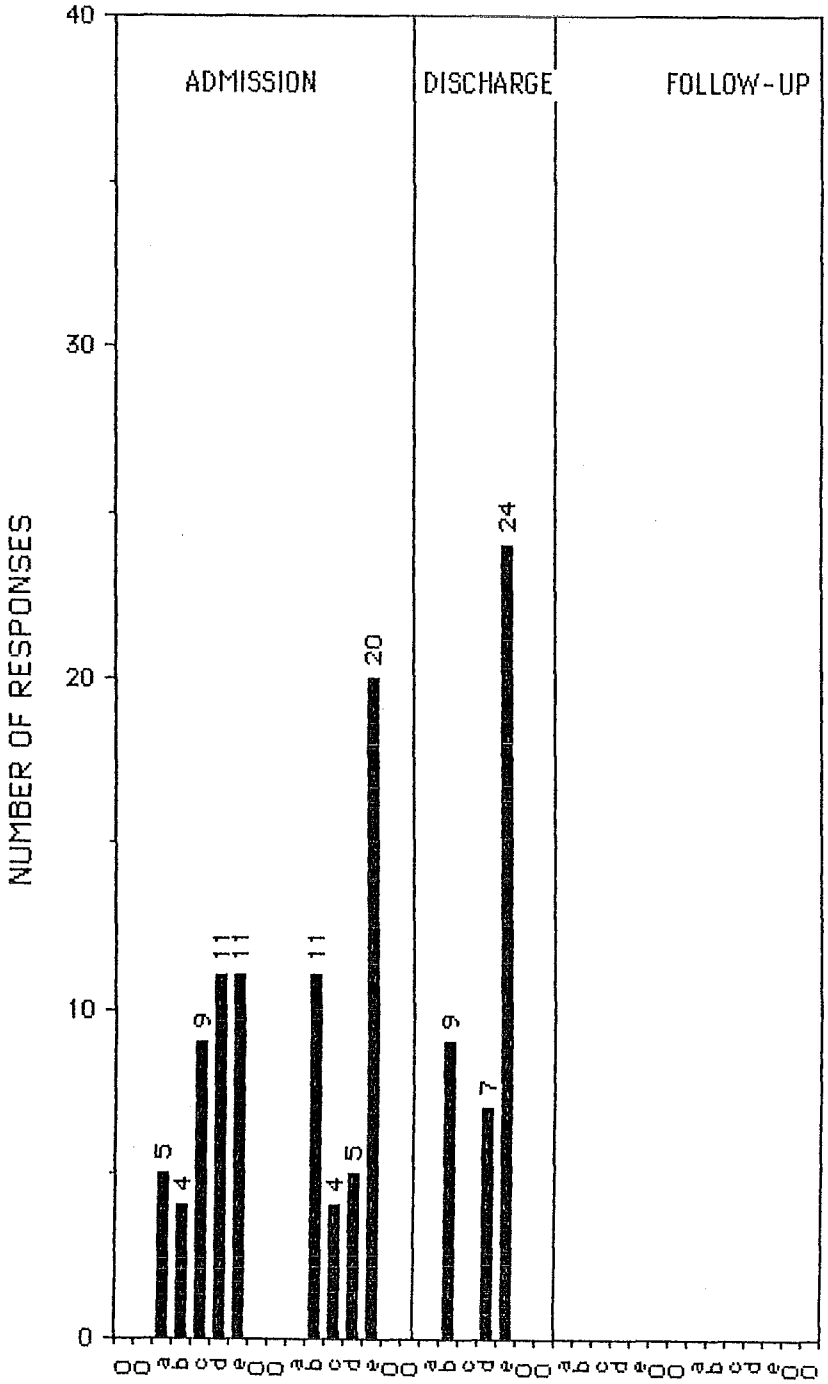


TITLE : LEVELS OF SELF-EFFICACY AT SPECIFIC POINTS IN THE PROGRAM.

FATHER = 1 AND MOTHER = 2

QUESTION = 1 OR 2.

FIGURE 3D(2,1)

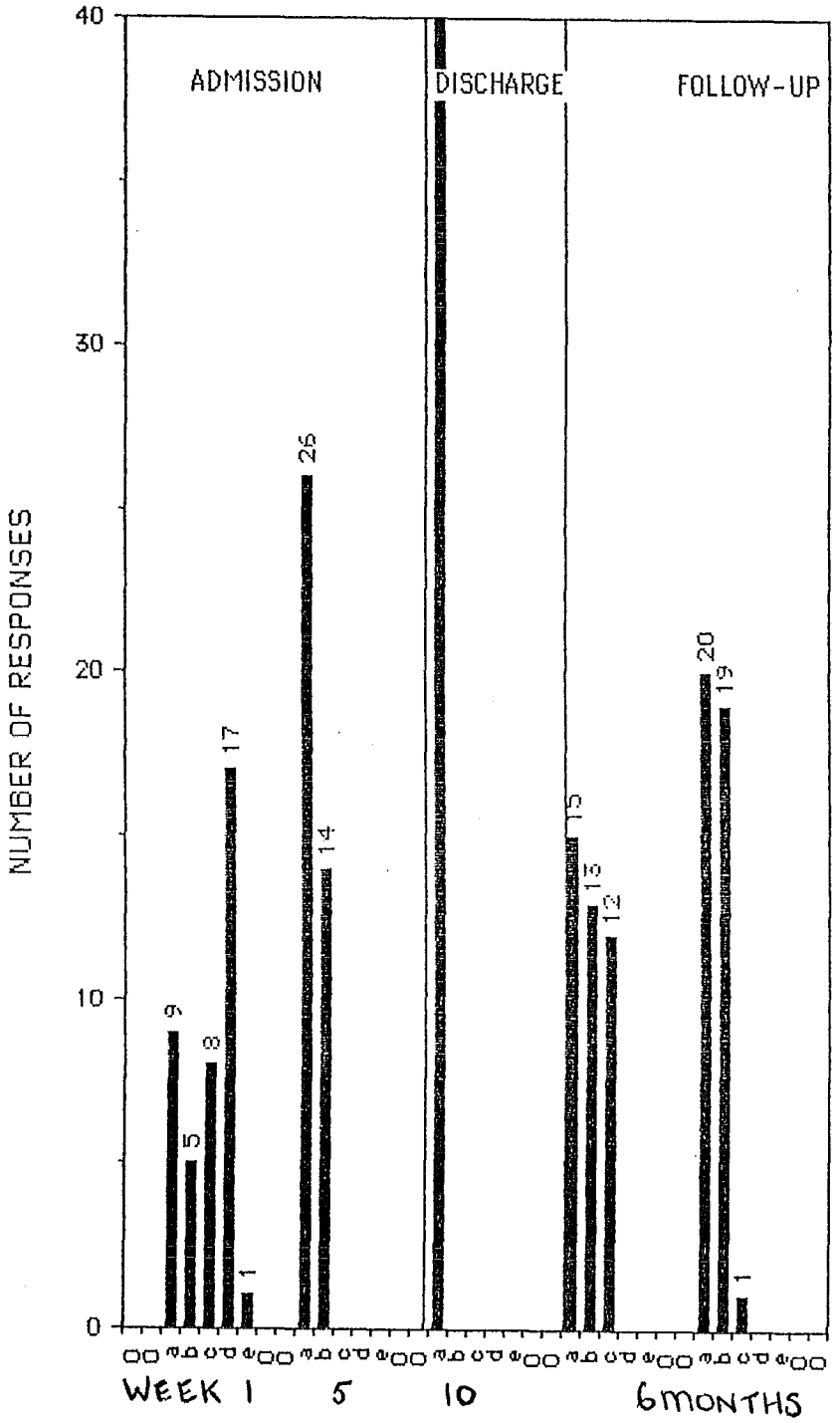


TITLE : LEVELS OF SELF-EFFICACY AT SPECIFIC POINTS IN THE PROGRAM.

FATHER = 1 AND MOTHER = 2

QUESTION = 1 OR 2.

FIGURE 3E(2,1)



LEVELS OF SELF-EFFICACY

TABLE 5 : FAM A : LEVELS OF SELF-EFFICACY
QUESTION 1, FATHER(1) AND MOTHER(2)

TIME	a		b		c		d		e	
	1	2	1	2	1	2	1	2	1	2
1	11	7	13	13	14	17	1	3	1	0
2	13	12	18	16	8	9	0	3	1	0
3	9	12	19	16	11	12	0	0	1	0
4	15	6	17	15	7	19	0	0	1	0
5	6	14	22	14	10	12	1	0	1	0
6	0	12	22	19	11	9	6	0	1	0
7	0	13	24	19	15	8	0	0	1	0
8	7	14	19	17	13	9	1	0	0	0
9	4	9	27	22	8	9	1	0	0	0
10	7	10	23	20	10	10	0	0	0	0
11	0	10	17	16	23	14	0	0	0	0

INPATIENT

TABLE 5 : CONTINUED :

TIME	a		b		c		d		e	
	1	2	1	2	1	2	1	2	1	2
12	0	7	26	21	14	12	0	0	0	0
13	0	4	27	24	13	12	0	0	0	0
14	3	4	24	23	13	13	0	0	0	0
15	0	6	29	18	11	16	0	0	0	0
16	0	4	28	21	11	15	1	0	0	0
17	4	4	21	24	15	12	0	0	0	0
18	4	5	20	24	16	11	0	0	0	0
19	7	5	21	25	12	10	0	0	0	0
20	8	7	23	27	9	6	0	0	0	0
21	9	7	22	28	9	5	0	0	0	0
F/U	9	2	24	28	6	4	0	0	0	0
F/U	9	2	25	28	6	10	0	0	0	0

OUTPATIENT

TABLE 6 : FAM B : CONFIDENCE PROFILES
QUESTION 1, FATHER(1) AND MOTHER(2)

TIME	a		b		c		d		e	
	1	2	1	2	1	2	1	2	1	2
1	1	1	1	4	15	8	10	7	4	20
2	---	---	---	---	---	---	---	---	---	---
3	1	0	3	5	26	6	6	6	3	25
4	1	1	2	2	25	8	9	10	2	11
5	2	2	0	1	28	9	7	7	2	21
6	---	---	---	---	---	---	---	---	---	---
7	---	0	---	2	---	4	---	9	---	25
8	---	---	---	---	---	---	---	---	---	---
9	0	0	4	3	14	9	17	6	4	22
10	1	0	4	2	19	9	12	8	3	21
11	0	0	3	3	18	12	14	13	4	12

INPATIENT

TABLE 6 : CONTINUED

TIME	a		b		c		d		e	
	1	2	1	2	1	2	1	2	1	2
12	0	0	3	3	17	12	17	12	2	13
13	0	0	3	10	20	11	12	11	4	8
14	---	0	---	12	---	14	---	10	---	4
15	0	0	4	9	20	12	11	12	4	7
16	0	0	3	4	22	17	11	12	3	7
17	0	0	11	8	12	10	19	15	6	7
18	---	---	---	---	---	---	---	---	---	---
19	0	0	3	8	20	12	14	16	2	4
20	0	0	3	0	21	16	12	8	3	8
21	0	0	2	7	21	14	12	17	4	2
F/U	0	0	2	7	28	13	8	12	1	8
F/U	0	0	2	8	30	15	6	8	1	9

OUTPATIENT

TABLE 7 : FAM C : LEVELS OF SELF-EFFICACY

QUESTION 1, FATHER(1) AND MOTHER(2)

TIME	a		b		c		d		e		
	1	2	1	2	1	2	1	2	1	2	
1	9	0	10	14	13	24	7	2	1	0	OUTPATIENT
2	13	0	10	25	7	13	8	2	2	0	
3	16	0	11	24	4	14	6	2	3	0	
4	19	0	8	25	7	14	6	1	0	0	
5	22	0	7	26	6	13	5	1	0	0	
6	24	0	7	27	8	12	1	1	0	0	
7	---	0	---	30	---	10	---	0	---	0	
8	25	0	4	28	9	11	2	1	0	0	
9	25	0	6	28	8	11	1	1	0	0	
10	21	0	9	30	9	9	1	1	0	0	
11	24	0	6	29	6	9	4	2	0	0	

TABLE 7 : CONTINUED

TIME	a		b		c		d		e		
	1	2	1	2	1	2	1	2	1	2	
12	21	0	6	28	7	11	6	1	0	0	OUTPATIENT
13	23	0	6	28	5	11	6	1	0	0	
14	21	0	8	29	6	10	5	1	0	0	
15	20	0	8	30	6	10	6	0	0	0	
16	---	---	---	---	---	---	---	---	---	---	
17	23	0	6	29	7	11	4	0	0	0	
18	---	---	---	---	---	---	---	---	---	---	
19	---	---	---	---	---	---	---	---	---	---	
20	---	---	---	---	---	---	---	---	---	---	
21	---	---	---	---	---	---	---	---	---	---	
F/U	19	17	9	8	8	13	4	2	0	0	
F/U	20	16	10	13	7	10	3	1	0	0	

TABLE 8 : FAM B – LEVELS OF SELF-EFFICACY
QUESTION 1, FATHER(1) AND MOTHER(2)

TIME	a 1	a 2	b 1	b 2	c 1	c 2	d 1	d 2	e 1	e 2	
1	---	---	---	---	---	---	---	---	---	---	
2	8	5	7	4	8	9	5	11	12	11	
3	6	8	8	6	12	7	6	9	8	10	
4	---	---	---	---	---	---	---	---	---	---	
5	4	6	1	7	13	8	8	7	12	12	
6	9	3	4	10	16	5	3	9	8	13	
7	7	4	7	9	14	5	7	9	5	13	
8	9	5	6	9	13	4	5	10	7	12	
9	6	3	13	8	9	2	1	17	11	10	
10	4	0	9	8	13	2	7	16	7	14	
11	0	0	10	11	17	4	6	5	7	20	INPATIENT

--- = MISSING VALUES

TABLE 8 : CONTINUED

TIME	a 1	a 2	b 1	b 2	c 1	c 2	d 1	d 2	e 1	e 2	
12	2	0	9	13	18	0	5	5	6	22	
13	2	0	11	13	19	0	4	6	4	21	
14	---	---	---	---	---	---	---	---	---	---	
15	---	---	---	---	---	---	---	---	---	---	
16	1	0	7	11	8	2	11	4	13	23	
17	0	0	8	9	16	3	9	9	7	19	
18	---	---	---	---	---	---	---	---	---	---	
19	0	0	3	9	16	0	4	7	17	24	
20	---	---	---	---	---	---	---	---	---	---	
21	---	---	---	---	---	---	---	---	---	---	OUTPATIENT
F/U	---	---	---	---	---	---	---	---	---	---	
F/U	CHILD NOT PRESENT IN THE FAMILY AT FOLLOW-UP.										

--- = MISSING VALUES

Scanner’s Note: Page 109 is absent from the original thesis

TABLE 9 : FRM E – LEVELS OF SELF-EFFICACY

QUESTION 1, MOTHER(2)

TIME	a 2	b 2	c 2	d 2	e 2	
1	---	---	---	---	---	
2	9	5	8	17	1	
3	9	7	13	11	0	
4	---	---	---	---	---	
5	14	18	8	0	0	
6	16	21	3	0	0	
7	14	9	16	1	0	
8	---	---	---	---	---	
9	37	3	0	0	0	
10	26	14	0	0	0	
11	---	---	---	---	---	INPATIENT

TABLE 9 : CONTINUED

TIME	a 2	b 2	c 2	d 2	e 2	
12	38	2	0	0	0	
13	39	1	0	0	0	
14	---	---	---	---	---	
15	40	0	0	0	0	
16	40	0	0	0	0	
17	40	0	0	0	0	
18	40	0	0	0	0	
19	---	---	---	---	---	
20	---	---	---	---	---	
21	40	0	0	0	0	
F/U	15	13	12	0	0	
F/U	20	19	1	0	0	OUTPATIENT

--- = MISSING

SECTION THREE : The analysis of management self-efficacy requires comparison of self-efficacy ratings with behavioural performance ratings completed for the child by the parents and staff. Data was not satisfactorily completed by the primary therapists on either the RBPC or the VAS. However, the parents all completed a satisfactory proportion of the data.

Table 10 provides the results from calculated (measurement on visual analogue) target behaviour scores for each week of the focus child's treatment. Data was incomplete for all families during the weeks 6 to 10. Fam E did not complete the requirements. Each target behaviour measurement was scored out of a possible 100 and then averaged across all the behaviours score(refer to Appendix). This provided a general behavioural quantification of the child's weekly performance. The MSE columns refer to total scores provided on page three of the MSE questionnaire which required parents to rate their self-efficacy for the target behaviours. Most families recorded scores for 5 target behaviours per week. These specific self-efficacy ratings for the target behaviours resulted in fairly stable evaluations across time even if the behavioural evaluations fluctuated. Self-efficacy from Fam D continued to drop over the five weeks parallel with the behavioural evaluations. The response scores from the MSE by the father of Fam B also dropped considerably from 20 to 14. It is difficult to evaluate these trends because of the limited information available on the management

experiences of the parents, and the measurements are generalised behaviour evaluations corresponding over a period of a week, while the MSE evaluations are specific to the time thy were completed.

A closer look at the illustrated data supports the initial assumption that specific and discrete behavioural and corresponding self-efficacy ratings are very difficult to interpret. However, there are some points worth noting. Firstly, as shown in figures 5 A, C and D target behavioural measures on the VAS were very similar for both of the parents in each family. Secondly, scores on the MSE and VAS often corresponded, for instance figures 4A and 5A indicate that these parents were averaging about a 'b' response for the five target behaviours recorded. Their MSE ratings are in the 15 to 20 range. Their recordings for the target behaviours are in the 40 to 60 range. Fam D show this correspondence to, but their scores on the MSE and VAS are lower. This is to be expected after the analysis of the total MSE scores in section one.

FIGURE 4A : MSE SCORES FOR FAM A.

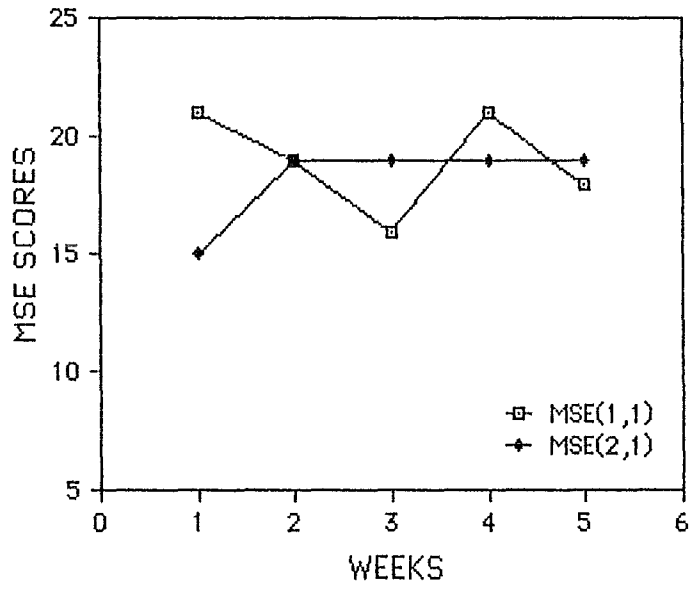


FIGURE 5A : TARGET BEHAVIOURS FOR FAM A.

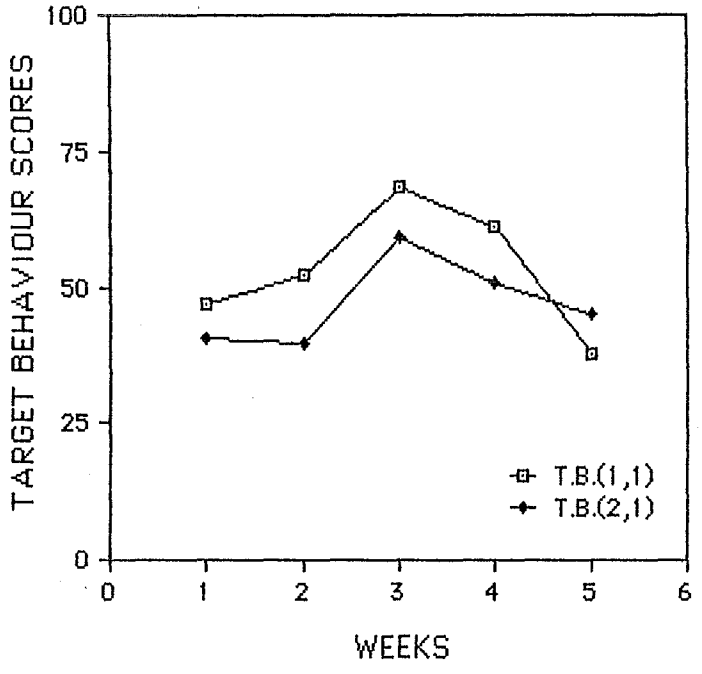


FIGURE 4B : MSE SCORES FOR FAM B.

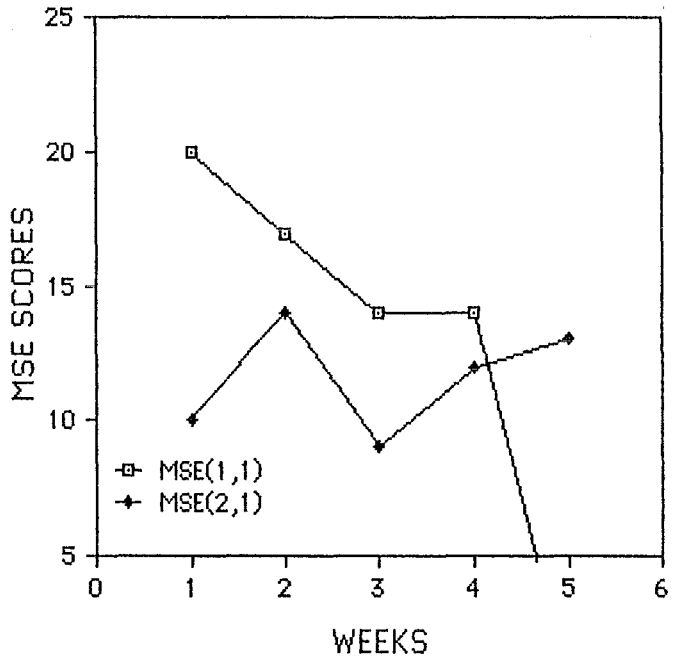


FIGURE 5B : TARGET BEHAVIOURS FOR FAM B.

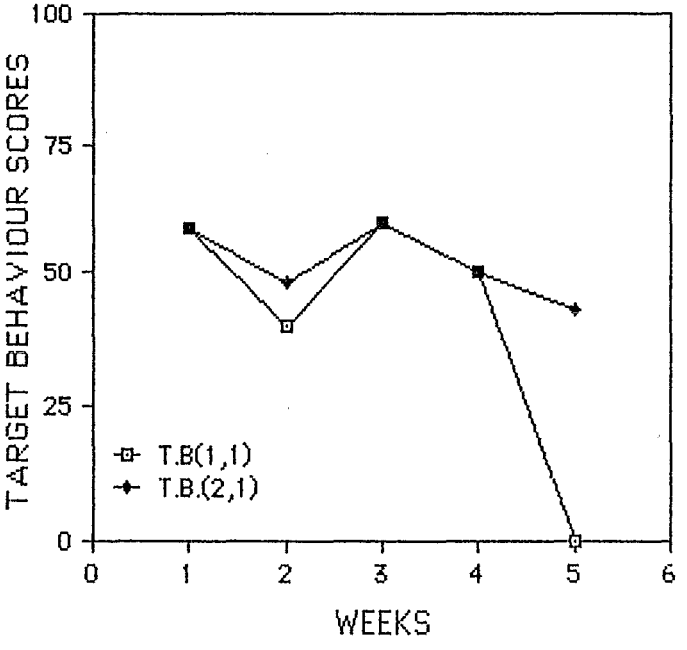


FIGURE 4C : MSE SCORES FOR FAM C.

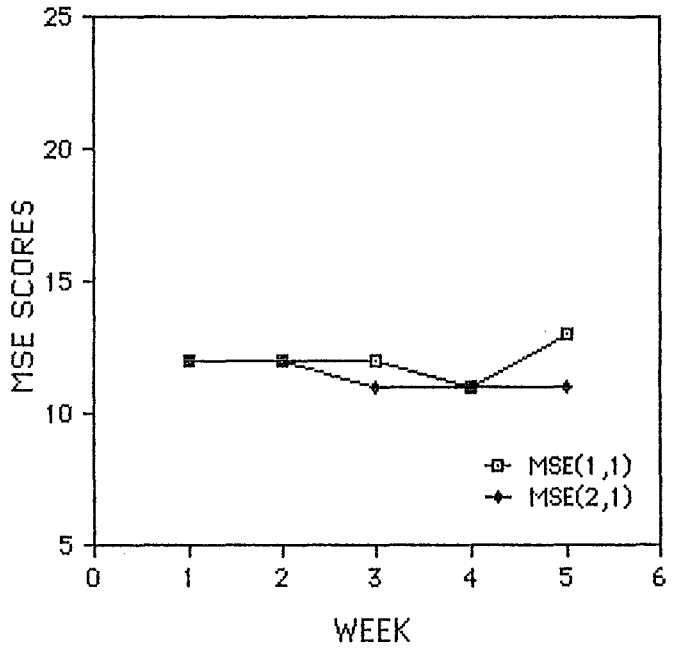


FIGURE 5C : TARGET BEHAVIOURS FOR FAM C.

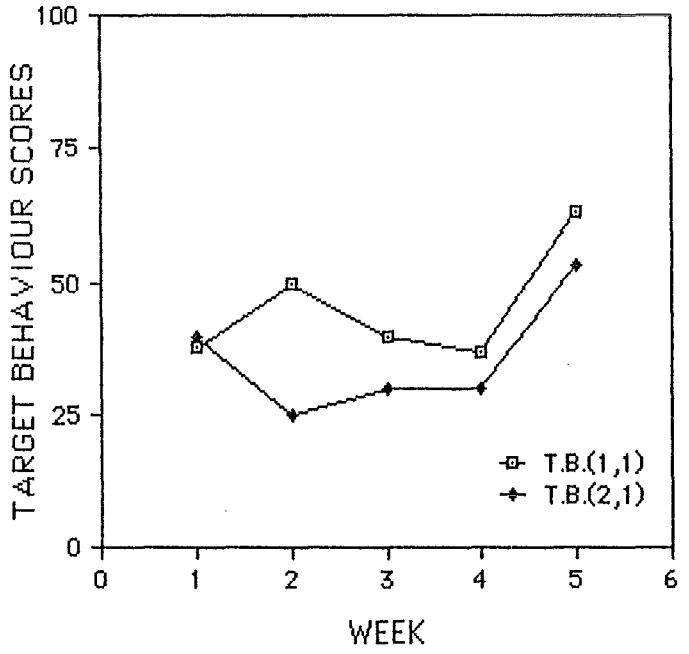


FIGURE 4D : MSE SCORES FOR FAM D.

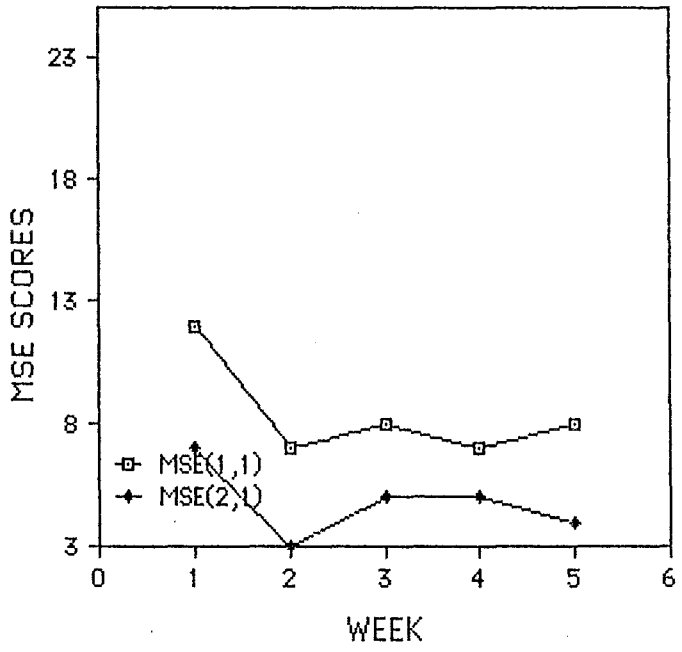


FIGURE 5D : TARGET BEHAVIOURS FOR FAM D.

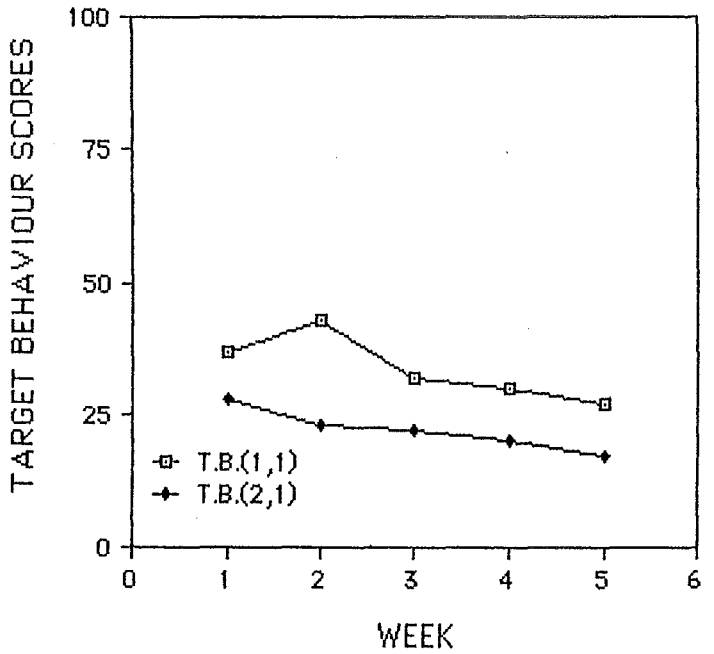


TABLE 10 : MSE (SUBTOTAL) AND TARGET BEHAVIOURS.

WEEKS	1		2		3		4		5	
	T.B	MSE	T.B	MSE	T.B	MSE	T.B	MSE	T.B	MSE
FAM A1	47	21	52.5	19	60.4	16	61	21	30	18
FAM A2	41	15	40	19	59	19	51	19	45	19
FAM B1	59	20	48	17	60	14	50	14	---	---
FAM B2	59	10	48	14	60	9	50	12	43	13
FAM C1	38	12	50	12	40	12	37	11	63	13
FAM C2	40	12	25	12	30	11	30	11	53	11
FAM D1	37	12	43	7	32	8	30	7	27	8
FAM D2	28	7	23	3	22	5	20	5	17	4

--- = MISSING VALUES

T.B = TARGET BEHAVIOUR

MSE = MANAGEMENT SELF-EFFICACY

FATHER = 1 AND MOTHER = 2.

In Tables 11 and 12 the results from the RBPC are presented. The checklists provide a more thorough assessment of a wider range of behaviours. Answering of the RBPC also provided a specific evaluation of behaviour, not a general retrospective one. The scores, though incomplete, indicate some important trends in the behaviour analysis. Parents from Fam A, B and C perceived their their child's behaviour as improving over time, and especially on the higher sub-scores (i.e.conduct disorder and attention deficit). Fam D scored a higher evaluation on the checklist at discharge compared to admission. This is consistent with the other behavioural findings on the VAS.

Following on from this, the comparison between parents evaluations of their self-efficacy in manageing their child and the trends in behavioural analysis, some tentative conclusions can be reached.

1. Child behavioural performance covaries with total MSE scores over time. This is only indicated with the more global behavioural measure (RBPC).

2. An increase in the severity of the managed problems will covary with a lowering of self-efficacy. The decline in self-efficacy score seemed to be assentuated during inpatient treatment due to high expectations of outcome.

3. A decrease in the severity of the management problems will covary with an increase in self-efficacy rating. If

the child's behaviour improved during the inpatient period, the parents often experienced a drop in self-efficacy following this as they attempted full-time management again.

TABLE 11 : ADPC SCORES FOR FATHER

		1	2	3	4	5	6	TOTAL	
FAM A	1	16	2	14	1	4	3	40	PRE-VISIT
	2	20	1	16	1	4	2	44	ADMISSION
	3	22	3	11	2	5	2	45	DISCHARGE
	4	15	2	3	2	0	2	24	SHORT-TERM
	5	16	2	5	3	0	2	28	LONG-TERM
FAM B	1								
	2	39	16	22	19	6	6	108	
	3	36	15	20	18	6	8	103	
	4	33	13	17	8	3	3	77	
	5	33	13	16	11	6	7	86	
FAM C	1								
	2	1	0	8	13	4	2	28	
	3								
	4								
	5	0	0	7	10	6	5	28	
FAM D	1								
	2	28	9	18	9	4	6	54	
	3	35	9	23	13	8	8	96	
	4								
	5								

1 = CONDUCT DISORDER 2 = SOCIALISED AGGRESSION

3 = ATTENTION DEFICIT 4 = ANXIETY-WITHDRAWAL

5 = PSYCHOTIC 6 = MOTOR EXCESS

TABLE 12 : RBPC SCORES FOR MOTHER

		1	2	3	4	5	6	TOTAL	
FAM A	1	19	1	9	1	3	3	36	PRE-VISIT
	2	24	3	18	3	3	3	46	ADMISSION
	3	24	2	7	3	3	2	41	DISCHARGE
	4	23	1	7	5	1	2	39	SHORT-TERM
	5	21	4	11	1	1	1	39	LONG-TERM
FAM B	1								
	2	42	22	23	21	9	8	125	
	3	35	17	21	18	7	8	106	
	4	38	16	22	17	8	6	107	
	5	43	18	22	18	18	9	118	
FAM C	1								
	2	8	0	10	12	6	2	38	
	3								
	4								
	5	1	0	15	14	10	7	46	
FAM D	1								
	2	41	10	22	7	11	7	98	
	3	42	18	24	13	10	8	115	
	4								
	5								

1 = CONDUCT DISORDER 2 = SOCIALISED AGGRESSION

3 = ATTENTION DEFICIT 4 = ANXIETY-WITHDRAWAL

5 = PSYCHOTIC 6 = MOTOR EXCESS

TABLE 12 CONTINUED : RBPC SCORES FOR MOTHER

		1	2	3	4	5	6	TOTAL	
FAM E	1								PRE-VISIT
	2	28	1	12	9	3	6	59	ADMISSION
	3	3	1	6	2	0	2	14	DISCHARGE
	4	0	0	0	0	0	0	0	SHORT-TERM
	5	23	1	11	7	4	5	51	LONG-TERM

1 = CONDUCT DISORDER 2 = SOCIALISED AGGRESSION

3 = ATTENTION DEFICIT 4 = ANXIETY-WITHDRAWAL

5 = PSYCHOTIC 6 = MOTOR EXCESS

CHAPTER FOUR - DISCUSSION

Attempting research in an inpatient unit, such as Ward 24, was a challenging task. Due to the occupational and therapeutic demands of the program, it was always going to be difficult trying to engage staff and parents. However, the staff and parents who participated in this research project provided some very valuable information both in the completing of the questionnaires and in the discussion of their experiences while involved in the program. The results and conclusions are limited due to the difficulty in engaging subjects and maintaining their compliance during the data collection period.

Interviews and discussions with the parent(s) involved in the research study address some important issues. Clearly, each family is dealing intensely with their own psychological well-being and began the Ward 24 program under considerable stress. They were all needy families, wanting support and assistance in the management of their children (child). This was demonstrated with the high non-compliance rate of subjects, who dealt with extremely demanding emotinal issues such as incest, alcoholism and problem drinking behaviour, physical abuse of the child and depression.

All the parents expressed their confusion relating to what they saw as a sudden change in the program at the end of five weeks. The primary therapist, after being daily involved with the child during the 5 week inpatient period,

was more difficult to contact and less available during the 5 week follow-up. At times, the short-term intervention program appeared to be limiting for the families (i.e. they wanted to experiemce more rpid changes in their child) and this experience is well supported by the fact that three families (of the five analysed) are continuing with long-term professional support.

As the structure of the program changed from inpatient to outpatient so the parents perceptions of their child's behaviour changed. Inpatient and oupatient phases of the program were very different experiences for each family. Once the 5 week follow-up period began, the parents fell like they were having to start again. At the 6 month follow-up for the research, the Ward 24 program seemed like a small part of a much bigger experience for all the parents. Life after Ward 24 was reported to have remained challenging, demanding and often a struggle.

Gladly, most of the parents expressed a growing sense of control and confidence, helped immeasurably by the professional input of the Ward 24 staff. It is not possible to quantify this experience, but they often described a sense of 'distancing' from the issues and conflicts; an increased objective attitude to the family problems. This can be directly attributed to a number of important learning experiences they obtained during the short-term program.

Firstly, practice of guidelines and consequences in the home and the implementation of a structured regime of

discipline based on classical and operant behaviour modification principles. Secondly, modeling through the observation of staff handling difficult situations with children on the ward.
Thirdly, becoming more aware of alternative methods of handling problems. This avoided frustration and anger with the focus child. Knowing what to expect, how to act, enabled them to feel in control and manage their child with increased confidence.

Self-efficacy theory is helpful in explaining this phenomena of increased confidence in coping with child management situations. The numerous experiences provided by the Ward 24 program enhanced the individual's personal self-efficacy, though at times they fluctuated during the inpatient phase, and increased after discharge as they familiarised themselves with their child again.
Persistence, in the face of low mood or a 'bad week' occurred, because the families were developing consistent, structured management guidelines. In the face of continual failure it was possible to observe a deterioration in their persistence and therefore, confidence. One family relinguished their management responsibilities.

During the inpatient period of treatment all the parents attributed any changes in their child's behaviour to the program and staff involved in management. This example of an environment-referent expectation changed during the short-term follow-up. The parents began the full-time task of management again, and started to

attribute their child's changes as self-referent expectations. Learning for the parents was predominantly vicarious for the first 5 weeks, but then became performance based as they experienced successful executions of management. Situations of difficult management developed perseverence. The parents were making self-corrective adjustments from performance feedback.

Data obtained from the parents on the VAS indicated that self-efficacy can be quite independent from specific behavioural evaluations of target behaviours. Confidence in child management is influenced by other things such as : the marital relationship, feelings of well-being and a variety of causal attributions. Overall parent management self-efficacy seems to be closely influenced by two things:
1. increased knowledge and skills on how to handle difficult situations,
2. outcome expectations of professional help.

The two variables focused on in this research were a measure of parent management self-efficacy during a treatment program and the corresponding measures of the focus child's behaviour, as perceived by the parents. The implication was that management of children requires skills and abilities. An individual judges their effectiveness in performing management tasks. The result of successful parent management was perceiving improvement in their child's behaviour. From the hypotheses suggested earlier it was concluded that their is a relationship experienced between management self-efficacy and child behavioural

performance, and that success on a task will tend to enhance self-efficacy if the person believes they were involved in the change.

However, it is difficult to make any definitive conclusions to this study. Tentative conclusions are suggested in explaining the data obtained. Further exploration of such issues, for example, as parent management and confidence in ability, perceptions of self-efficacy changes over time, inpatient versus outpatient treatment options and the question of subject/treatment fit, and parent evaluation of behavioural performance during treatment, are recommended. Evaluations of expensive and time consuming programs such as Ward 24 are paramount.

Furthermore, the instrumentation used for the study requires some refinement. The MSE was considered to be to lengthy by all parents. If it had been shorter some of the non-compliant families may have cooperated. There were examples of behaviours on the questionnaire that were not applicable to the focus child. These may have been unneccessary for a self-efficacy evaluation. Behavioural and self-efficacy evaluation needs to correspond more closely, especially the detail of parent management experiences during the treatment phases. The language of the questionnaire needs to be simplified. Some non-compliant families found the questionnaire literally daunting.

Interpretation of the RBPC is tentative. Quay and Peterson suggest a conservative interpretation of the scores. A score Two (or greater) standard deviations from the mean is required to be considered clinically meaningful. Fam A, B and C recorded high in Conduct Disorder and Attention Deficit groupings close to 2 S.D. from the clinical mean. Fam D scores noticeably increased after the inpatient phase. In retrospect, these results support the hypotheses suggesting a covariant relationship between child behavioural performance and parents perceptions of their management self-efficacy.

In conclusion, this study has provided valuable clinical and research experience. The task of combining the ideals of research and investigation with the reality of peoples lives remains a hurdle for any researcher. It also provides valuable information during the process.

REFERENCES

Aman, M.G., Weery, J.S., Fitzpatrick, J., Lowe, M., & Waters, J. (1983). Factor structure and norms for the Revised Behaviour Problem Checklist in New Zealand children. Australian and New Zealand Journal of Psychiatry, 17, 354-360.

Anders, T.F. (1977). Child Psychiatry and Pediatrics : The state of the relationship. Pediatrics, 60(4), 616-620.

Anders, T.F., & Niehans, M. (1982). Promoting the alliance between Pediatrics and Child Psychiatry. Psychiatric Clinics of North America, 5(2), 241-258.

Anderson, C. (1977). Family intervention with severely disturbed inpatients. Archive of General Psychology, 34, 697-702.

Bandura, A. (1977). Self-efficacy : Towards a unifying theory of behavioural change. Psychological Review, 84(2), 191-215.

Bandura, A. & Adams, N.E. (1977). Analysis of self efficacy theory of behavioural change. Cognitive Therapy and Research, 1, 287-308.

Bandura, A., Adams,N.E. & Beyer, J. (1977). Cognitive processes mediating behavioural change. Journal of Personality and Social Psychology, 35(3), 125-139.

Bandura, A. (1978a). On paradigms and recycled ideologies. Cognitive Therapy and Research, 2(1), 79-103.

Bandura, A. (1978b). The self system in reciprocal determinism. American Psychologist, 33, 344-358.

Bandura, A. (1978c). Reflections on self-efficacy. Advances in Behavioural Research and Therapy, 1, 237-269.

Bandura, A. (1978d). On distinguishing between logical and empirical verification : A comment on Smedslund. Scandinavian Journal of Psychology, 19, 97-99.

Bandura, A. (1980). Gauging the relationship between self-efficacy, judgement and action. Cognitive Therapy and Research, 4(2), 263-268.

Bandura, A., Adams, N.E., Hardy,A.B., & Howells, G.H. (1980). Tests of generality of self-efficacy theory. Cognitive Therapy and Research, 4(1), 122-147.

Bandura, A. (1982). Self-efficacy mechanism in human agency. American Psychologist, 37(2), 122-147.

Bandura, A. (1984). Recycling misconceptions of perceived self-efficacy. Cognitive Therapy and Research, 8(3), 231-255.

Bandura, A. et al (1985). Catecholamine secretion as a function of perceived self-efficacy. Journal of Consulting and Clinical Psychology, 53(3), 406-414.

Bandura, A. (1986) Social Foundations of Thought and Action : A Social Cognitive Theory. New Jersey : Prentice-Hall.

Barker, P.A. (Ed). (1974). The Residential Psychiatric Treatment of Children. Great Britain : Granada Publishing Co.

Barker, P.A. (1976). Basic Child Psychiatry (2nd ed.). Baltimore : University Park Press.

Barrett, C.L., Hampe, I.E., & Miller, L.C. (1978). In S.L. Garfield & A.E.Bergin (2nd ed.), The Handbook of Psychotherapy and Behaviour Change : an empirical analysis. New York : John Wiley & Sons.

Beck, A.T. (1976) Cognitive Therapy and Emotional Disorders. New York : International Universities Press.

Berlin, I.N. (1975). Some models of reversing the myth of child treatment in community mental health centers. Journal of the American Academy of Child Psychiatry, 14(1), 76-94.

Berlin, I.N. (1978). Developmental issues - The psychiatric hospitalisation of children. American Journal of Psychiatry, 135, 1044-1048.

Bingley, L., Leonard, J., Hensman, S., Lask, B., & Wolff, O. (1980). Comprehensive management of children on a pediatric ward : a family approach. Archives of Disease in Childhood, 55, 555-561.

Biran, M. & Wilson, G.T. (1981). Treatment of phobic disorders using cognitive and exposure models : A self-efficacy analysis. Journal of Consulting and Clinical Psychology, 49(6), 886-899.

Blinder, B.J., Young, W.M., Fineman, K.R., & Miller, S.J. (1978). The children's psychiatric hospital unit in the community : 1. Concept and development. American Journal of Psychiatry, 135(7), 848-851.

Bolles, R.C. (1972) Reinforcement, expectancy and learning, Psychological Review, 79, 394-409.

Borkovec, T.D. (1977). Self-efficacy : Cause or reflection of behavioural change? Advances in Behaviour Reseach and Therapy, 1, 163-170.

Brody, N. (1980). Social motivation. Annual Review of Psychology, 31, 143-168.

Capra, F. (1982) The Turning Point. London : Fontana Books.

Chambliss, C., & Murray, E.J. (1979). Cognitive procedures for smoking reduction : Symptom attribution versus efficacy attribution. Cognitive Therapy and Research, 3(1), 91-95.

Chambliss, C., & Murray, E.J. (1979). Efficacy attribution, locus of control and weight loss. Cognitive Therapy and Research, 3(4), 349-353.

Chess, S. (1969) An introduction to child psychiatry, (2nd Ed). New York : Grune and Stratton.

Condiotte, M., & Lichenstein, E. (1981) Self-efficacy and relapse in smoking cessation programs. Journal of Consulting and Clinical Psychology, 49(5), 648-658.

Coopersmith, S. (1967) The antecedents of self-esteem. San Francisco : Freeman.

Cotton, N.S., & Geraty, R.G. (1984). Therapeutic space design : Planning an inpatient children's unit. American Journal of Orthopsychiatry, 54(4), 624-636.

Dulcan, M.K. (1984). Brief psychotherapy with children and their families : The state of the art. Journal of American Academy of Child Psychiatry, 23(5), 544-551.

DeCharms, R. (1978) Personal causation : The internal affective determinants of behaviour. New York : Academic Press.

Eastman, C., & Marzillier, J.S. (1984). Theoretical and methodological difficulties in Bandura's self-efficacy

theory. Cognitive Therapy and Research, 8(3), 213-229.

Ewart, C.K., Taylor, C.B., Reese, L.B., & DeBusk, R.F. (1983) Effects of early post-myocardial infarction exercise testing on self-perception and subsequent physical activity. American Journal of Cardiology, 51, 1076-1080.

Epstein, N.B. & Vlok, L.A. (1981). Research on the results of Psychotherapy: A summary of evidence. American Journal of Psychiatry, 138, 1027-1035.

Eysenck, H.J. (1978). Expectations as causal elemants in behavioural change. Advances in Behaviour Research and Therapy, 1, 171-175.

Frommer, E.A. (1972). Diagnosis and treatment oin clinical child Psychiatry. London : William Heinemann Medical Books Ltd.

Gibb, F. (1984) MSC Theses. University of Canterbury.

Goldfried, M.R., & Robins, C. (1982). On the facilitation of self-efficacy. Cognitive Therapy and Research, 6(4), 361-380.

Griest, D.L., Forehand,R., Rogers, T., Breirer, J., Furey, W., & Williams, C.A. (1982). Effects of parent enhancement therapy on the treatment outcome and generalisation of a parent training program. Behaviour Research and Therapy, 20, 429-436.

Hall, S. (1984). MA Theses, University of Canterbury.

Harbin, H. (1979). A family oriented in-patient unit. Family Process, 8, 281-292.

Harbin, A. (1982). The Psychiatric Hospital and the

Family. New York : Spectrum Publications Inc.

Heinecke, C.M., & Strassman, L.H. (1975). Toward more effective research on child psychotherapy. The American Academy of Child Psychiatry, 561-588.

Hersov, L. & Bentovim, A. (1977). Inpatient units and day hospitals. In M. Rutter & L. Hersov (Ed), Modern approaches to child and adolescent psychiatry. Oxford : Blackwell Scietific Publications.

Hersov, L. & Bentovim, A. (1985). In-patient and Day-Hospital Units. In M. Rutter & L. Hersov (Ed), Modern approaches to child and adolescent psychiatry. Oxford : Blackwell Scietific Publications.

Hildebrand, J., Jenkins, J., Carter, D. & Lask, B. (1981). The introduction of a family orientation in a child psychiatric inpatient unit. Journal of Family Therapy, 13, 139-152.

Hollandsworth, J.G., Jr., Glazeski, R.C., Kirkland, K, Jones, G.E. & van Norman, L.R. (1979). An analysis of the nature and effects of test anxiety : Cognitive, behavioural, and physiological components. Cognitive Therapy and Research, 3, 165-180.

Kaplan, H.I., & Sadock, B.J. (1985). Modern synopsis of comprehensive textbook of psychiatry/4. U.S.A. : Williams and Wilkins.

Kazdin, A.E. (1978). Behaviour therapy , evolution and expansion. The Counselling Psychologist, 7(3), 34-37.

Kazdin, A.E. (1978). Conceptual and assessment issues raised by self-efficacy theory. Advances in Behaviour Research and Therapy, 1, 177-185.

Kazdin, A.E., & Rogers, T. (1978). On paradigms and recycled ideologies : Analogue research revisited. Cognitive Therapy and Research, 2(1), 105-117.

Kazdin, A.E. (1979). Imagery elaboration and self-efficacy in the covert modeling treatment of unassertive behaviour. Journal of Consulting and Clinical Psychology, 47, 725-733.

Lansky, M. (1977). Establishing a family-oriented in-patient unit. Journal of Operational Psychiatry, 8, 66-74.

Laslett, R. (1975) Aspects of change in the education of maladjusted children. Journal of Associated Work with Maladjusted children, 3, 13-19.

Lenz, E. & Myerhoff, B. (1985). The Feminization of America. Los Angeles : Jeremy P. Tarcher, Inc.

Levitt, E.E. (1957). The results of psychotherapy with children : An evaluation. Journal of Consulting Psychology, 21, 186-189.

Levitt, E.E. (1963). Psychotherapy with children : A further evaluation. Behaviour Research and Therapy, 60, 326-329.

Looney, J.G. (1984). Treatment planning in child psychiatry. Journal of American Academy of Child Psychiatry, 23(5), 529-536.

McDermott, J.F. (1984). Psychotherapy with children and adolescents : Introduction. Journal of the American Academy of Child Psychiatry, 23(5), 527-528.

McDermott, J.F., & Char, W.F. (1984). Stage-related models of psychotherapy with children. Journal of the American Academy of Child Psychiatry, 23(5), 537-543.

Maddux, J.E., Sherer, M., & Rogers, R.W. (1982). Self-efficacy expectancy and outcome expectancy : Their relationship and their effects on behavioural intentions. Cognitive Therapy and Research, 6(2), 207-211.

Mandelbaum, A. (1977). A family centred approach to residential treatment. Bulletin-Menninger Clinic, 41, 27-39.

Markus, H. (1977). Self-schemata and processing information about the self. Journal of Personality and Social Psychology, 35, 63-78.

Marzillier, J., & Eastman, C. (1984). Continuing problems with self-efficacy theory : A reply to Bandura. Cognitive Therapy and Research, 8(3), 257-262.

Meichenbaum, D.H. (1977). Cognitive-Behaviour modification : an integrative approach. New York : Plenum.

Miller, B.C. (1986). Family Research Methods, London : Sage Publications.

Moe, K.O., & Zeiss, A.M. (1982). Measuring self-efficacy expectations for social skills : A methodological inquiry. Cognitive Therapy and Research, 6(2), 191-205.

Moss, G.R. & Boren, J.J. (1971). Specifying criteria for completion of psychiatric treatment : a behaviouristic approach. Archives of General Psychiatry, 24, 441-447.

Moss, G.R., & Levine, M.J. (1980). A developmental, educational and behavioural approach to hospital. Psychiatric Clinics of North America, 33, 501-511.

Nakhla, F., Folkart, L., & Webster, J. (1969) Treatment

of families as in-patients. Family Process, 8, 79-96.

Ney, P.G., & Mulvihill, D. (1985). Child Psychiatric Treatment : A practical guide. London : Croom Helm Publishers.

Nisbett, R., & Wilson, T.D. (1977). Telling more than we can know. Verbal reports on mental processes. Psychological Bulletin, 84, 231-259.

Palmer, A.J., Harper, G., & Rivinus, T.M. (1983). The "Adoption Process" in the inpatient treatment of children and adolescents. Journal of the American Academy of Child Psychiatry, 22(3), 286-293.

Poser, E.G. (1978). The self-efficacy concept : Some theoretical, procedural and clinical implications. Advances in Behaviour, Research and Therapy, 1, 193-202.

Redl, F., & Wineman, D. (1952). Children who hate. New York : Free Press.

Rioch, D.M., & Stanton, A.H. (1953) Milieu therapy. Psychiatry, 16, 65-72.

Robinson, J.F. (1947) Resident psychiatric treatment of children. American Journal of Orthopsychiatry, 17, 484-487.

Robinson, J.F. (Ed).(1957) Psychiatric inpatient treatment of children. Washington, D.C. : American Psychiatric Association.

Romanczyk, R.G., Kistner, J.A., & Crimmins, D.B. (1979). Institutional treatment of severely disturbed children : fact, possibility or nonsequitur? In B.B. Lahey & A.E. Kazdin (Ed). Advances in Clinical Child

Psychology, 3. New York & London : Plenum Press.

Ro-trock, G.K., Wellisch, D.K., & Schoolar, J.C. (1977). A family therapy study in an inpatient setting. American Journal of Orthopsychiatry, 47(3), 514-522.

Rotter, J.B. (1954) Social learning and clinical psychology. New Jersey : Prentice-Hall.

Rotter, J.B. (1966) Generalised expectancies for internal versus external control of reinforcement. Psychological Monographs, 80(1), 1-26.

Rutter, M., & Hersov, L. (1977, 1985). Child Psychiatry : modern approaches. Oxford : Blackwell Scientific Publications.

Sack, W.H., & Blocker, D.L. (1979). Who gets referred? Child psychiatric consultation in a pediatric hospital. International Journal of Psychiatry in Medicine, 9(3&4).

Sappington, A., Russell, C., Triplett, V., & Goodwin, J. (1981). Self-efficacy expectations, emotionally based expectancies and their relationship to avoidant behaviour and its reduction through therapy. Journal of Clinical Psychology, 37(4), 737-744.

Schulman, J.L. & Irwin, M. (Ed). (1982) Psychiatric Hospitalisation of Children. Illinois : Charles C. Thomas.

Schunk. D.H. (1983a April-June). Goal difficulty and attainment information : Effects on children's achievement behaviours. Human Learning : Journal of Practical Research and Applications, 2(2), 107-117.

Schunk. D.H. (1983b Dec). Ability vs effort

attributional feedback : Differential effects on self-efficacy and achievement. Journal of Educational Psychology, 75(6), 848-856.

Schunk, D.H. (1984a). Sequential attributional feedback and children's achievement behaviours. Journal of Educational Psychology, 76(6), 1159-1169.

Schunk, D.H. (1984b). Enhancing self-efficacy and achievement through rewards and goals : Motivational and informational effects. Journal of Educational Research, 78(1), 29-34.

Schween, P., & Gralnick, A. (1966). Factors affecting family therapy in a hospital setting. Comprehensive Psychiatry, 7, 424-431.

Seligman, M.E.P. (1975) Helplessness : On depression, development, and death. San Francisco : Freeman.

Shaffer, D. (1984). Notes : Psychotherapy research amoung children and adolscents. Journal of American Academy of Child Psychiatry, 23(5), 552-561.

Shaffii, M., Mccue, A., Ice, J.F., & Schwab, J.J. (1979). The development of an acute short-term inpatient child psychiatric setting : A pediatric-psychaitric model. American Journal of Psychiatry, 136(4), 427-429.

Smedslund, J. (1978). Bandura's theory of self-efficacy : A set of common sense theorems. Scandinavian Journal nf Psychology, 19, 1-14.

Smedslund, J. (1978). Some psychological theories are not empirical : Reply to Bandura. Scandinavian Journal of Psychology, 19, 101-102.

Smith, E. R. & Miller, F.D. (1978). Limits on perception of cognitive processes : A reply to Nisbett and

Wilson. Psychological Review, 85, 355-362.

Smith, C., & Murphy, K.E. (1984). Developing a Children's Inpatient Psychiatric unit. Journal of Psychosocial Nursing, 22(3), 31-36.

Sonis, M. (1967) Residential treatment. In A.L. Freedman & H.L. Kaplan. (Ed) Comprehensive textbook of psychiatry. Baltimore : Williams & Wilkins.

Steiner, H. (1982) The socio-therapeutic environment of a child psychosomatic ward (or is paediatrics bad for your health?). Child psychiatry and human development, 13(2), 71-78.

Strupp, H.H., & Hadley, S.W. (1977). A tripartite model of mental health and therapeutic outcomes : with special reference to negative effects in psychotherapy. American Psychologist, 32, 187-196.

Takata, C. & Takata, T. (1976) The influence of models on the evaluation of ability : Two functions of social comparison processes. The Japanese Journal of Psychology, 47, 74-84.

Weinberg, R.S., Gould, D., & Jackson, A. (1979) Expectations and performance : An experiemntal test of Bandura's self-efficacy theory. Journal of Sport Psychology, 1, 320-331.

White, R.W. (1959) Motivation reconsidered : The concept of competence. Psychological Review, 66v, 297-333.

Wilking, V.N. (1974). The division of child psychiatry. Psychiatric Annals, 4(5), 56-70.

Williams, J., Lewis, C., Capeland, F., Tucker, L., & Feagan, L. (1978). A model for short-term group therapy on

a children's inpatient unit. Clinical Social Work Journal, 6(1), 21-32.

Wilson, T. (1974). Creating a diversified activity program in a small psychiatric institution for children. Child Care Quarterly, 6(4), 249-258.

Wilson, G.T. (1978). The importance of being theoretical : A commentary on Bandura's "Self-efficacy : Towards a unifying theory of behaviour change". Advances in Behaviour Research and Therapy, 1, 217-230.

Wilkinson, T.R. (1983). Child and Adolescent Psychiatric Nursing. Melbourne Blackwell Scientific Publications.

Wine, J.D., & Smye, M.D. (Ed). (1981). Social Competence. New York, London : The Guilford Press.

Witmer, H.L. (1935) A comparison of treatment results in various types of child guidance clinics. American Journal of Orthopsychiatry, 51, 351-360.

Wolpe, J. (1974) The practice of behaviour therapy. New York : Pergamon.

Wolpe, J. (1978) Self-efficacy theory and pschotherapeutic change : A square peg for a round hole. Advances in Behaviour Research and Therapy, 1, 231-236.

PARENT MANAGEMENT SELF-EFFICACY

Listed below are situations that you may experience as parents. Please answer every question.

We would like to know:

(1) How confident would you be in dealing with each of these situations?

a	always confident
b	very confident
c	sometimes confident
d	seldom confident
e	never confident

(2) How confident are you that you can cope with each of these situations, having not coped on the previous occasion?

1	extremely confident
2	very confident
3	moderately confident
4	mildly confident
5	not confident

N.B. Answer each question for yourself and how it is for you at this moment.

Date: _____ Time: _____

	Questions (1)	(2)
1. When your child is restless and cannot sit still.		
2. When your child is disruptive and tends to annoy others.		
3. When your child is boisterous and rowdy.		
4. When your child cries for minor annoyances and hurts.		
5. When your child is socially withdrawn.		
6. When your child demonstrates a short attention span.		
7. When your child is fighting others.		
8. When your child has a temper tantrum.		
9. When your child has bad companions.		
10. When your child is disobedient.		

	Questions (1)	(2)
11. When your child is depressed and unhappy.		
12. When your child is uncooperative.		
13. When your child is active and 'always on the go.'		
14. When your child is enuretic and wets the bed.		
15. When your child is getting picked on at school.		
16. When your child enjoys being with you.		
17. When your child has physical ailments and/or handicaps.		
18. When your child has difficulty communicating with others.		
19. When your child shouts to get attention.		
20. When your child swears and abuses you.		
21. When your child wants to be entertained by you.		
22. When your child is difficult at the meal table.		
23. When your child is unaffectionate and avoids kissing/hugging you.		
24. When your child cheats and/or is dishonest.		
25. When your child is disinterested in things around him/her.		
26. When your child chews on inedible things.		
27. When your child steals or abuses others' property.		
28. When your child runs away from your discipline.		
29. When your child soils his/her pants and/or is encopretic.		
30. When your child is shy and easily embarrassed.		
31. When your child steals from other people.		
32. When your child is absentminded and forgets simple things easily.		
33. When your child is selfish and does not share things.		
34. When your child cannot resist leaving your side.		
35. When your child gives up easily and lacks perseverance.		
36. When you are feeling under pressure.		
37. When you want to relax.		
38. When you do not feel good about yourself.		
39. When your punishment seems ineffective.		
40. When you feel alone in the parenting/disciplining of your child.		

PARENT MANAGEMENT SELF-EFFICACY

NB Continuation of Questionnaire adding described target behaviours from the visual analogue scale, e.g. eating at meal table.

	Questions (1)	(2)
41. Target behaviour		
42. Target behaviour		
43. Target behaviour		
44. Target behaviour		
45. Target behaviour		
46. Target behaviour		
47. Target behaviour		
48. Target behaviour		

PLUS

Record daily number of visits to Ward 24 and involvement with staff. Estimate the amount of time spent in ½ hour blocks. Each category describes the type of contact on the ward.

	DATE	Parent Training	Therapy Appointment	Informal Teaching	Visiting/ Other	TOTAL
e.g.	Mon 13th	1 hr	3 hr	0	1 hr	5 hr

REVISED BEHAVIOR PROBLEM CHECKLIST

1.	Restless; unable to sit still	0	1	2
2.	Seeks attention; "shows-off"	0	1	2
3.	Stays out late at night	0	1	2
4.	Self-conscious; easily embarrassed	0	1	2
5.	Disruptive; annoys and bothers others	0	1	2
6.	Feels inferior	0	1	2
7.	Steals in company with others	0	1	2
8.	Preoccupied; "in a world of his own;" stares into space	0	1	2
9.	Shy, bashful	0	1	2
10.	Withdraws; prefers solitary activities	0	1	2
11.	Belongs to a gang	0	1	2
12.	Repetitive speech; says same thing over and over	0	1	2
13.	Short attention span; poor concentration	0	1	2
14.	Lacks self-confidence	0	1	2
15.	Inattentive to what others say	0	1	2
16.	Incoherent speech, what is said doesn't make sense	0	1	2
17.	Fights	0	1	2
18.	Loyal to delinquent friends	0	1	2
19.	Has temper tantrums	0	1	2
20.	Truant from school, usually in company with others	0	1	2
21.	Hypersensitive; feelings are easily hurt	0	1	2
22.	Generally fearful; anxious	0	1	2
23.	Irresponsible, undependable	0	1	2
24.	Has "bad" companions, ones who are always in some kind of trouble	0	1	2
25.	Tense, unable to relax	0	1	2
26.	Disobedient; difficult to control	0	1	2
27.	Depressed; always sad	0	1	2
28.	Uncooperative in group situations	0	1	2
29.	Passive, suggestible; easily led by others	0	1	2
30.	Hyperactive; "always on the go"	0	1	2
31.	Distractible; easily diverted from the task at hand	0	1	2
32.	Destructive in regard to own and/or other's property	0	1	2
33.	Negative; tends to do the opposite of what is requested	0	1	2
34.	Impertinent; talks back	0	1	2
35.	Sluggish, slow moving, lethargic	0	1	2
36.	Drowsy; not "wide awake"	0	1	2
37.	Nervous, jittery, jumpy; easily startled	0	1	2
38.	Irritable, hot-tempered; easily angered	0	1	2
39.	Expresses strange, far-fetched ideas	0	1	2
40.	Argues; quarrels	0	1	2
41.	Sulks and pouts	0	1	2
42.	Persists and nags; can't take "no" for an answer	0	1	2
43.	Avoids looking others in the eye	0	1	2
44.	Answers without stopping to think	0	1	2
45.	Unable to work independently; needs constant help and attention	0	1	2
46.	Uses drugs in company with others	0	1	2
47.	Impulsive; starts before understanding what to do; doesn't stop and think	0	1	2
48.	Chews on inedible things	0	1	2
49.	Tries to dominate others; bullies, threatens	0	1	2
50.	Picks at other children as a way of getting their attention; seems to want to relate but doesn't know how	0	1	2
51.	Steals from people outside the home	0	1	2

(please turn over)

52.	Expresses beliefs that are clearly untrue (delusions)	0	1	2
53.	Says nobody loves him or her	0	1	2
54.	Freely admits disrespect for moral values and laws	0	1	2
55.	Brags and boasts	0	1	2
56.	Slow and not accurate in doing things	0	1	2
57.	Shows little interest in things around him or her	0	1	2
58.	Does not finish things; gives up easily; lacks perseverance	0	1	2
59.	Is part of a group that rejects school activities such as team sports, clubs, projects to help others	0	1	2
60.	Cheats	0	1	2
61.	Seeks company of older, "more experienced" companions	0	1	2
62.	Knows what's going on but is listless and uninterested	0	1	2
63.	Resists leaving mother's (or other caretaker's) side	0	1	2
64.	Difficulty in making choices; can't make up mind	0	1	2
65.	Teases others	0	1	2
66.	Absentminded; forgets simple things easily	0	1	2
67.	Acts like he or she were much younger; immature, "childish"	0	1	2
68.	Has trouble following directions	0	1	2
69.	Will lie to protect his friends	0	1	2
70.	Afraid to try new things for fear of failure	0	1	2
71.	Selfish; won't share; always takes the biggest piece	0	1	2
72.	Uses alcohol in company with others	0	1	2
73.	School work is messy, sloppy	0	1	2
74.	Does not respond to praise from adults	0	1	2
75.	Not liked by others; is a "loner" because of aggressive behavior	0	1	2
76.	Does not use language to communicate	0	1	2
77.	Cannot stand to wait; wants everything right now	0	1	2
78.	Refuses to take directions, won't do as told	0	1	2
79.	Blames others; denies own mistakes	0	1	2
80.	Admires and seeks to associate with "rougher" peers	0	1	2
81.	Punishment doesn't affect his or her behavior	0	1	2
82.	Squirms, fidgets	0	1	2
83.	Deliberately cruel to others	0	1	2
84.	Feels he or she can't succeed	0	1	2
85.	Tells imaginary things as though true; unable to tell real from imagined	0	1	2
86.	Does not hug and kiss members of family; affectionless	0	1	2
87.	Runs away; is truant from home	0	1	2
88.	Openly admires people who operate outside the law	0	1	2
89.	Repeats what is said to him or her; "parrots" others' speech	0	1	2

	CD	SA	AP	AW	PB	ME
Raw Score	_____	_____	_____	_____	_____	_____
T Score	_____	_____	_____	_____	_____	_____

Date _____

FORM II

SCORE SHEET FOR REVISED BEHAVIOR PROBLEM CHECKLIST (RBPC).

I CONDUCT DISORDER	II SOCIALIZED AGGRESSION	III ATTENTION DEFICIT
2____	3____	13____
5____	7____	15____
17____	11____	23____
19____	18____	29____
26____	20____	31____
28____	24____	35____
33____	46____	36____
34____	51____	44____
38____	54____	45____
40____	59____	47____
41____	60____	56____
42____	61____	58____
49____	69____	66____
50____	72____	67____
55____	80____	68____
65____	87____	73____
71____	88____	TOTAL _____
75____	TOTAL _____	
77____		
78____		
79____		
83____		
TOTAL _____		

IV ANXIETY-WITHDRAWAL	V PSYCHOTIC BEHAVIOR	VI MOTOR EXCESS
4____	12____	1____
6____	16____	25____
9____	39____	30____
14____	52____	37____
21____	85____	82____
22____	89____	TOTAL _____
27____	TOTAL _____	
53____		
64____		
70____		
84____		
TOTAL _____		

DIAGNOSTIC CRITERIA BY PARENTAL AND/OR PATIENT REPORT AND BY FIRST HAND OBSERVATION (to be filled in by assessor)

0 = not true
1 = no more than most children of his/her age
2 = true (except where otherwise stated, "reported" symptoms to have been present for at least 6/12)

REPORTED				OBSERVED		
0	1	2	distinct appetite change for at least two weeks	0	1	2
0	1	2	distinct weight change for at least two weeks	0	1	2
0	1	2	very easily distractable	0	1	2
0	1	2	tends to be violent towards property and even people	0	1	2
0	1	2	unrealistic worry about harm to or separation from parent - figures (for at least two weeks)	0	1	2
0	1	2	unable to relax, very tense	0	1	2
0	1	2	no interest/pleasure in friends or group activities	0	1	2
0	1	2	temper tantrums	0	1	2
0	1	2	unresponsive to other people since before age 2 1/2	0	1	2
0	1	2	unexplained panic attacks and/or catastrophic reactions	0	1	2
0	1	2	peculiar movements and/or posturing	0	1	2
0	1	2	mentally retarded (psychologist's assessment)	0	1	2
0	1	2	change in sleep pattern for at least two weeks	0	1	2
0	1	2	very inattentive - doesn't seem to listen	0	1	2
0	1	2	dishonest (stealing, lying)	0	1	2
0	1	2	persistent school refusal for at least two weeks	0	1	2
0	1	2	very self-conscious, easily embarrassed	0	1	2
0	1	2	avoidance of contacts, even same age-group, outside family	0	1	2
0	1	2	provocative, negativistic and disobedient behaviour	0	1	2
0	1	2	peculiar speech patterns since before age 2 1/2	0	1	2
0	1	2	resistance to change with insistence on daily routines (e.g. clothing rituals)	0	1	2
0	1	2	preoccupied, "in a world of his own"	0	1	2
0	1	2	has significant hearing problems (by medical assessment)	0	1	2
0	1	2	apathetic; no interest or pleasure in activities or hobbies for at least two weeks	0	1	2
0	1	2	very impulsive - can't wait - acts without thinking	0	1	2
0	1	2	substance abuse (e.g. alcohol, drugs, petrol or glue sniffing)	0	1	2
0	1	2	refuses to sleep without parent-figure present (for at least two weeks)	0	1	2
0	1	2	preoccupied with own lack of competence	0	1	2
0	1	2	defective language development before age 2 1/2	0	1	2
0	1	2	over or undersensitive to ordinary sensations	0	1	2
0	1	2	hears things (e.g. voices) that are not present (hallucinates	0	1	2
0	1	2	clumsy; awkward; poor muscular coordination	0	1	2
0	1	2	no energy at all for at least two weeks	0	1	2
0	1	2	overly active; constantly restless or "on the go"	0	1	2
0	1	2	runs away from school and/or home	0	1	2
0	1	2	frequent nightmares for at least two weeks	0	1	2
0	1	2	excessive need for reassurance	0	1	2
0	1	2	odd response to or strange attachments to things around him/her since before age 2 1/2	0	1	2
0	1	2	mutilates self (e.g. hitting and biting self; banging head)	0	1	2
0	1	2	odd bizarre ideas; beliefs not according with reality (delusions)	0	1	2
0	1	2	intense fear of fatness, even when very thin	0	1	2
0	1	2	stutters	0	1	2
0	1	2	at least two weeks' lack of concentration	0	1	2
0	1	2	cannot keep friends over six months	0	1	2
0	1	2	physical symptoms on schooldays (e.g. headaches, stomachaches at least two weeks)	0	1	2
0	1	2	incoherence, hard to make sense of what child is saying	0	1	2
0	1	2	eats non-nutritive substances	0	1	2
0	1	2	wets his/her pants and/or bed regularly	0	1	2
0	1	2	self reproach, feelings of worthlessness for at least two weeks	0	1	2
0	1	2	shows no remorse nor sense of guilt nor concern for others (even his/her companions)	0	1	2
0	1	2	physical complaints (e.g. headaches, stomach aches), with no clear physical basis, for at least two weeks	0	1	2
0	1	2	shrinks excessively from contact with strangers only	0	1	2
0	1	2	binge-eating with vomiting and/or stomachache	0	1	2
0	1	2	sleepwalks repeatedly	0	1	2
0	1	2	ideas of death or suicide for at least two weeks	0	1	2
0	1	2	soils his/her pants or elsewhere frequently	0	1	2
0	1	2	has repetitive, rapid, purposeless movements (tics)	0	1	2
0	1	2	lacks appropriate emotional responsivity	0	1	2

Name of Reporter_____ Name of Observer_____

0 = not true
1 = no more than most children of his/her age
2 = true (except where otherwise stated, "reported" symptoms to have been present for at least 6/12)

PREADMISSION

WARD 24 CHILD AND FAMILY UNIT

BEHAVIOUR PROBLEM CHECKLIST

Child's Name _____ Date _____

Please indicate which of the following constitute problems, so far as your child is concerned at the present time.

If an item is not a problem, circle the zero;
If an item is a mild problem, circle the one;
If an item is a severe problem, circle the two.
Please complete every item.

None	Mild	Severe		
0	1	2	1.	Oddness, bizarre behavior.
0	1	2	2.	Restlessness, inability to sit still.
0	1	2	3.	Attention-seeking, "show-off" behavior.
0	1	2	4.	Stays out late at night.
0	1	2	5.	Doesn't know how to have fun; behaves like a little adult.
0	1	2	6.	Self-consciousness; easily embarrassed.
0	1	2	7.	Fixed expression, lack of emotional reactivity.
0	1	2	8.	Disruptiveness; tendency to annoy and bother others.
0	1	2	9.	Feelings of inferiority.
0	1	2	10.	Steals in company with others.
0	1	2	11.	Boisterousness, rowdiness.
0	1	2	12.	Crying over minor annoyances and hurts.
0	1	2	13.	Preoccupation; "in a world of his own".
0	1	2	14.	Shyness, bashfulness.
0	1	2	15.	Social withdrawal, preference for solitary activities.
0	1	2	16.	Dislike for school.
0	1	2	17.	Jealousy over attention paid other children.
0	1	2	18.	Belongs to a gang.
0	1	2	19.	Repetitive speech.
0	1	2	20.	Short attention span.
0	1	2	21.	Lack of self-confidence.
0	1	2	22.	Inattentiveness to what others say.
0	1	2	23.	Easily flustered and confused.
0	1	2	24.	Incoherent speech.
0	1	2	25.	Fighting.
0	1	2	26.	Loyal to delinquent friends.
0	1	2	27.	Temper tantrums.
0	1	2	28.	Reticence, secretiveness.
0	1	2	29.	Truancy from school.
0	1	2	30.	Hypersensitivity; feelings easily hurt.
0	1	2	31.	Laziness in school and in performance of other tasks.
0	1	2	32.	Anxiety, chronic general fearfulness.
0	1	2	33.	Irresponsibility, undependability.
0	1	2	34.	Excessive daydreaming.
0	1	2	35.	Masturbation.
0	1	2	36.	Has bad companions.
0	1	2	37.	Tension, inability to relax.
0	1	2	38.	Disobedience, difficulty in disciplinary control.
0	1	2	39.	Depression, chronic sadness.
0	1	2	40.	Uncooperativeness in group situations.
0	1	2	41.	Aloofness, social reserve.
0	1	2	42.	Passivity; suggestibility; easily led by others.

None	Mild	Severe		
0	1	2	43.	Clumsiness, awkwardness, poor muscular coordination.
0	1	2	44.	Hyperactivity; "always on the go".
0	1	2	45.	Distractibility.
0	1	2	46.	Destructiveness in regard to his own and/or other's property.
0	1	2	47.	Negativism, tendency to do the opposite of what's requested.
0	1	2	48.	Impertinence, sauciness.
0	1	2	49.	Sluggishness, lethargy.
0	1	2	50.	Drowsiness.
0	1	2	51.	Profane language, swearing, cursing.
0	1	2	52.	Nervousness, jitteriness, jumpiness; easily startled.
0	1	2	53.	Irritability; hot-tempered; easily aroused to anger.
0	1	2	54.	Enuresis, bed-wetting.
0	1	2	55.	Often has physical complaints, e.g. headaches, stomach-aches.

Add any other descriptions that apply to your child, but were not mentioned above:

0 1 2 _____

0 1 2 _____

0 1 2 _____

TARGET BEHAVIOURS

This visual analogue scale is to be completed by parents and staff primary therapist at the end of each week. The designated target behaviours are specific for each child. Complete each question by marking a cross (X) along the line to indicate your evaluation of the child's behaviour.

EATING AT THE MEAL TABLE

i.e. below average

very good ——————————X—————————— poor

——————————————————————————

——————————————————————————

——————————————————————————

——————————————————————————

——————————————————————————

——————————————————————————

TITLE : ANOVA SUMMARY TABLE FOR FAMILY (A).

SOURCE	SS	DF	MS	F	PROB.
MEAN	1904126.297	1	1904126.3	24555.79	0.00
PARENT	2030.583	1	2030.583	26.19	0.00
QUESTION	602.678	1	602.678	7.77	0.01
PQ	520.012	1	520.012	6.71	0.01
ERROR	6203.429	80	77.542		

TITLE : ANOVA SUMMARY TABLE FOR FAMILY (B).

SOURCE	SS	DF	MS	F	PROB.
MEAN	812036.67	1	812036.67	4605.53	-0.00
PARENT	3231.44	1	3231.44	18.33	0.00
QUESTION	762.011	1	762.011	4.32	0.04
PQ	223.44	1	223.44	1.27	0.26
ERROR	14105.43	80	176.32		

TITLE : ANOVA SUMMARY TABLE FOR FAMILY (C).

SOURCE	SS	DF	MS	F	PROB.
MEAN	1486265.76	1	1486265.76	20018.45	0.00
PARENT	6500.39	1	6500.39	87.55	0.00
QUESTION	165.76	1	165.76	2.23	0.14
PQ	79.39	1	74.39	1.0	0.32
ERROR	4454.687	60	74.24		

TITLE : ANOVA SUMMARY TABLE FOR FAMILY (D).

SOURCE	SS	DF	MS	F	PROB.
MEAN	618457.35	1	618457.35	3381.41	0.00
PARENT	0.011389	1	0.01389	0.00	0.9931
QUESTION	6903.125	1	6903.125	37.74	0.00
PQ	6593.347	1	6593.347	36.05	0.00
ERROR	12437.167	68	182.899		

TITLE : ANOVA SUMMARY TABLE FOR FAMILY (E).

SOURCE	SS	DF	MS	F	PROB.
MEAN	1180482.25	1	1180482.25	2014.42	0.00
QUESTION	12.25	1	12.25	0.02	0.84
ERROR	19924.50	34	586.01		

CANTERBURY HOSPITAL BOARD ETHICAL COMMITTEE

TREATMENT TRIAL OR INVESTIGATION - PATIENT CONSENT FORM

PROJECT TITLE:

PARENTAL SELF-EFFICACY AND CHILD MANAGEMENT

INVESTIGATORS:

MR MIKE PROUTING, ASSISTANT CLINICAL PSYCHOLOGIST
DR STEVE HUDSON, CLINICAL PSYCHOLOGIST, DR BILL WATKINS, CHILD PSYCHIATRIST
MS KARYN FRANCE

VENUE OF TRIAL:

WARD 24, CHRISTCHURCH HOSPITAL

AIM OF TRIAL OF NEW TREATMENT OR INVESTIGATION:

THE INVESTIGATION AIMS TO MEASURE AS OBJECTIVELY AS POSSIBLE CHANGES IN YOUR CHILD'S BEHAVIOUR, BOTH DURING THE ADMISSION PERIOD ON WARD 24, AND OVER A FOLLOW UP PERIOD OF 3 - 4 MONTHS FOLLOWING DISCHARGE. IT ALSO AIMS TO CHECK THE IDEA THAT SUSTAINED IMPROVEMENT IN YOUR CHILD'S BEHAVIOUR WILL BE CLOSELY LINKED TO YOUR CONFIDENCE IN FEELING YOU CAN INFLUENCE YOUR CHILD'S BEHAVIOUR WHEN YOU WANT

DESCRIPTION OF NATURE AND DURATION OF PATIENT'S INVOLVEMENT:

PARENTS ARE BEING ASKED TO COMPLETE UP TO SEVERAL TIMES A WEEK A QUESTIONNAIRE WHICH TAKES 15 - 30 MINUTES TO COMPLETE AND MEASURES SELF CONFIDENCE. PARTICIPATION WILL BE SPREAD OUT OVER 3 - 4 MONTHS

DESCRIPTION OF INCONVENIENCES OR HAZARDS WHICH MIGHT BE EXPECTED:

NO HAZARDS ARE ANTICIPATED
YOU AS A PARENT WOULD BE INCONVENIENCED BY THE AMOUNT OF TIME NEEDED TO COMPLETE THE QUESTIONNAIRES. THE TIME WILL RANGE FROM LESS THAN HALF AN HOUR, UP TO A MAXIMUM OF 1½ HOURS PER WEEK. WE HOPE YOU WILL BE WILLING TO GIVE THIS TIME.

STATEMENT BY PATIENT: (To be signed in the presence of a doctor)

I HAVE READ THE ABOVE AND HAVE HAD THE OPPORTUNITY FOR DISCUSSION WITH A DOCTOR. I UNDERSTAND THAT THE PROCEDURES HAVE BEEN APPROVED BY A SPECIAL HOSPITAL COMMITTEE AND THAT I MAY WITHDRAW MY AGREEMENT AT ANY TIME. I UNDERSTAND THIS WOULD NOT AFFECT MY CONTINUING TREATMENT OR CARE AT THE HOSPITAL. I UNDERSTAND THAT MY DOCTORS WILL DISCONTINUE THE TREATMENT OR INVESTIGATION IF ANY HARMFUL EFFECTS APPEAR. I AGREE TO TAKE PART IN THIS STUDY OR TRIAL OF TREATMENT.

Signature of (Patient) PARENT ____ Date ____

Signature of Doctor ____ Date ____